Strategic Plan for Oral Health in Oregon: Progress Report

2016

OREGON ORAL HEALTH COALITION

Oregon Health Authority

Oral Health Funders Collaborative
of Oregon and SW Washington

ENDORSEMENTS

The stakeholders listed below have endorsed the recommendations in the *Strategic Plan for Oral Health in Oregon: 2014-2020*.

- Advantage Dental
- AllCare Health
- Benton, Linn, Lincoln Regional Oral Health Coalition of Oregon
- Cambia Health Foundation
- Capitol Dental Care, Inc.
- CareOregon
- CareOregon Dental
- Central Oregon Oral Health Coalition
- Columbia Pacific CCO
- Dental Foundation of Oregon
- Health Share of Oregon
- Jackson Care Connect
- Kaiser Permanente
- Moda Health/Delta Dental of Oregon/ODS
- Multnomah County Health Department
- Northwest Health Foundation
- Oral Health Funders Collaborative of Oregon and Southwest Washington
- Oregon Child Development Coalition
- The Oregon Community Foundation
- Oregon Dental Association
- Oregon Dental Hygienists' Association
- Oregon Governor's Office
- Oregon Health & Science University and OHSU School of Dentistry
- Oregon Health Authority
- Oregon Oral Health Coalition
- Oregon Primary Care Association
- Permanente Dental Associates
- Providence Health & Services
- Samaritan Health Services
- Upstream Public Health
- Virginia Garcia Memorial Health Center
- Yamhill CCO
- Yamhill County Public Health

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November 10, 2016

Dear Oregonians,

Oral health is an essential component of overall health; it is fundamental to our well-being, productivity and quality of life. To reduce the social and economic cost of oral diseases and related illnesses, it is essential for all Oregonians to receive timely and equitable dental care throughout every stage of life.

In 2013, the Oregon Oral Health Coalition, the Oral Health Funders Collaborative and Oregon Health Authority came together with almost 200 oral health advocates to produce the *Strategic Plan for Oral Health in Oregon: 2014-2020*. This plan has served as an inspiration and guide for coordinated care organizations (CCOs), local oral health coalitions and other organizations around the state.

Thanks to the exceptional energy and commitment of Oregon's oral health advocates, our state has made progress toward the goals outlined in the *Strategic Plan*. However, there is more work to do. I commend the achievements we have made to date and believe we have built a strong foundation for future success. I strongly support continued efforts to improve oral health care integration as a key component of overall health for all Oregonians.

Everyone who cares about the health of our state should take the time to review this progress report, which outlines Oregon's record of success and innovation as well as the work that remains to be done to ensure that Oregonians of all ages receive timely, affordable and appropriate oral health care and preventive services.

Sincerely,

Lynne Saxton

Lynne Saxton
Director

CONTRIBUTORS

This biennial progress report is based on interviews with 50 diverse stakeholders — including care providers, insurance providers, public health experts, funders and state leaders — all of whom generously shared their time, knowledge and expertise to document the current state of oral health care in Oregon. This report was funded by the Oral Health Funders Collaborative, a partnership of 13 regional grantmakers who are coordinating their efforts to identify and invest in lasting oral health solutions for Oregon and Southwest Washington.

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STRATEGIC PLAN OVERVIEW

Priority Area 1: Infrastructure

OBJECTIVE 1	OBJECTIVE 2	Selected Outcome Measures
Oregon's oral health infrastructure delivers better care, better health and lower costs. 1. Oregon Health Authority (OHA) prioritizes oral health and provides leadership in state-level policy, funding and regulatory discussions and decisions. 2. OHA and its community partners expand and improve Oregon's oral health surveillance system. 3. Local and county oral health infrastructure facilitates equitable and timely access to oral health prevention, education and care.	***Oregon's oral health infrastructure reflects and supports health system transformation priorities.*** 1. Coordinated care organizations (CCOs) comprehensively integrate oral health. 2. Dental benefit packages align with preventive goals and provide adequate care to ensure optimal oral health maintenance and equitable outcomes across the lifespan. 3. Payment practices for dental services align with current billing and reimbursement models and with the Oregon Dental Practice Act.	• Oregon has an appropriately staffed, funded and empowered dental director (2015). • OHA develops a strategic plan to expand Oregon's oral health surveillance system (2015). • Oregon has a reporting database that tracks hospital emergency visits for nontraumatic dental problems (2017). • Health information systems include detailed data on race, ethnicity, language and other characteristics necessary to monitor oral health equity as required by state law (2017). • All school-based health centers and federally qualified health centers integrate oral health care into their activities (2018).

Priority Area 2: Prevention and Systems of Care

OBJECTIVE 1	OBJECTIVE 2	Selected Outcome Measures
Evidence-based prevention strategies are implemented across every Oregonian's lifespan. 1. Maintain or establish optimally fluoridated community water systems. 2. Include oral disease prevention in prenatal and pediatric programs. 3. Expand access to screenings, fluoride treatments and care for high-risk children. 4. Expand evidence-based, best-practice oral health programs in schools. 5. Provide community-based prevention, outreach, education and intervention to underserved adults and seniors. 6. Integrate oral health with chronic disease prevention and management.	***Oregonians achieve oral health literacy and understand that oral health is inseparable from overall health.*** 1. Develop a communications plan to educate all Oregonians on oral health. 2. Integrate oral health education into general health education for all ages.	• Population residing in communities with optimally fluoridated water • Pregnant women who had their teeth cleaned within the previous year • Children 0 to 5 with a dental visit in the previous year • Third graders with decay experience • Children 6 to 9 with dental sealants on one or more permanent molars • Individuals who have received First Tooth training • Eighth graders with decay experience • 11th graders with a dental visit in the previous year • Adults 18 and older with a dental visit in the previous year • ED utilizations for nontraumatic dental problems

Priority Area 3: Workforce Capacity

OBJECTIVE 1	OBJECTIVE 2	Suggested Outcome Measures
Oregon has an adequate and equitable distribution of oral health professionals. 1. Encourage oral health professionals to work at the top of their license. 2. Train traditional health workers and related professionals to provide basic preventive care and to connect community members with oral health providers. 3. Incentivize providers to work in rural and underserved areas. 4. Support pilot workforce projects made possible by Senate Bill 738. 5. Encourage retired professionals to return to practice as insured volunteers.	***Oregon's oral health workforce meets the lifelong oral health needs of all Oregonians, including underserved and vulnerable populations.*** 1. Foster a culturally competent oral health workforce. 2. Equip providers with education and technology to enable them to reach underserved patients. 3. Emphasize public health philosophy and practice in dental health professional curricula. 4. Integrate oral health education into the curricula for all health care providers.	• Number of expanded practice dental hygienists (EPDHs) practicing in Oregon communities. *Source: Oregon Dental Hygienists' Association (ODHA).* • Number of dental students completing a 30-day rural rotation. *Source: Oregon Health & Science University (OHSU).* • Proportion of underrepresented minority students admitted to dental programs. *Source: OHSU.* • Number of oral health care providers who completed cultural competency training as mandated by the Oregon Board of Dentistry. *Source: OHA.*

EXECUTIVE SUMMARY

Although a great deal of work remains to be done, the major accomplishments detailed in this progress report should be a source of pride and encouragement to everyone who is striving to improve oral health in our state.

The *Strategic Plan for Oral Health in Oregon* reflects an expert consensus on effective methods for optimizing oral health in our state. It identifies three priority areas: *Infrastructure*, *Prevention and Systems of Care* and *Workforce Capacity*. This biennial progress report assesses each area, highlighting Oregon's remarkable record of success and innovation as well as the work that still needs to be done to meet the objectives set forth in the *Strategic Plan*.

Priority Area 1: Infrastructure

Since the *Strategic Plan* was published in 2014, Oregon has seen a concerted effort to build state, regional and local oral health infrastructure and capacity. Here are some key accomplishments:

- Oregon now has a state dental director, which has led to a new era of cross-divisional collaboration on oral health.
- The State Health Improvement Plan (SHIP) recognizes oral health as a statewide priority.
- Legislative actions have expanded dental access for Oregonians of all ages.
- Medicaid expansion has increased adult dental benefits to include dentures, denture replacement and stainless-steel crowns.

Although Oregon has made substantial progress on all outcome measures, only one goal was completed on schedule: a reporting database that tracks emergency department visits for nontraumatic dental problems.

Priority Area 1: Outcome Measures	Target	Status
Oregon has an appropriately staffed, funded and empowered dental director per Association of State and Territorial Dental Directors (ASTDD) best practices.	2015	In Process
Oregon Health Authority (OHA) develops a strategic plan to improve and expand oral health surveillance.	2015	In Process
OHA's oral health program is adequately funded to implement the activities outlined here and in the Public Health Division's health improvement plan, and to meet ASTDD guidelines for state oral health programs.	2016	In Process
OHA Metrics and Scoring Committee adopts comprehensive metrics for oral health.	2016	In Process
Oral health coordinators serve each county through public health departments, nonprofits and other entities.	2016	In Process
Coordinated care organizations (CCOs) have comprehensively integrated oral health.	2016	In Process
Oregon's Centers for Medicare & Medicaid Services oral health program resolves discrepancies in billing and reimbursement practices.	2016	In Process
Oregon has a reporting database that tracks hospital emergency visits for nontraumatic dental problems.	2017	Completed
Health information systems include detailed data on race, ethnicity, language and other characteristics necessary to monitor oral health equity as required by state law.	2017	In Process
All school-based health centers (SBHCs) integrate oral health care into their activities.	2018	In Process
All federally qualified health centers (FQHCs) integrate oral health care into their activities.	2018	In Process

Recommendations

- Oregon's fee-for-service dental reimbursement rates vary by CCO. Medicaid reimbursement rates and alternative payment models should incentivize providers to serve Medicaid clients while also encouraging care coordination and oral health integration.
- CCOs and dental care organizations (DCOs) should take advantage of opportunities to align oral health priorities, agree on key performance and outcome measures, and share innovative practices.
- Oregon's health care advocates and workforce should continue working to coordinate and expand data collection and information sharing across organizations and agencies.
- Poor integration of electronic health records is hampering dental-medical-behavioral care coordination. Full integration should be promoted and incentivized.

Priority Area 2: Prevention and Systems of Care

Since 2014, Oregon's oral health efforts have focused mainly on preventive care for pregnant women and children. Services for this population include school-based sealant programs as well as screening and fluoride varnish programs in primary care settings and other non-dental sites. In 2012, Pew Charitable Trusts gave Oregon a B grade for its state sealant program. In 2015, the state received an A-. Although fewer programs specifically target adolescents, adults and seniors, general access has increased through innovative models such as teledentistry and the co-location of dental services with medical and behavioral health services.

The reporting of outcomes data varies by source; some numbers were not available by the time of publication. With the exception of water fluoridation, all outcome measures for which data were available as of 2016 show steady progress.

Priority Area 2: Outcome Measures	Baseline	Current	2020 Target	Target Change	Current Change
Population residing in communities with optimally fluoridated water	22.6%	22.2%	25%	10% ↑	-1.8% ↓
Pregnant women who had their teeth cleaned within the previous year	53.2%	58.3%	58.5%	10% ↑	9.6% ↑
Individuals who have received First Tooth training	3,046	4,398	8,000	162% ↑	44.3% ↑
Eighth graders with decay experience	70.1%	68.7%	63.1%	10% ↓	2.0% ↓
11th graders with a dental visit in the previous year	74.5%	74.9%	81.2%	10% ↑	0.5% ↑
Adults 18 and older with a dental visit in the previous year	63.8%	67.0%	70.2%	10% ↑	5.0% ↑

Recommendations

- Expand models of care for adolescents, seniors, people with special needs, people with chronic diseases, and homeless and undocumented residents.
- Foster engagement, inclusion and relationship building with advocates who serve specific communities of color and who understand their prevailing cultural attitudes, risk factors, trusted knowledge sources, and challenges relating to oral health.
- Sustain long-term communication and advocacy efforts for community water fluoridation, including the defense and maintenance of existing water fluoridation systems.
- Cultivate health care professionals and other knowledgeable individuals as community water fluoridation advocates.

Priority Area 3: Workforce Capacity

Lack of access to providers remains a major barrier to receiving care. Since 2014, the percentage of Oregonians living in a dental health professional shortage area (HPSA) has risen from 24 to 31 percent. This is not simply due to a lack of providers; it also stems from inequitable distribution, especially in rural areas. In response, significant efforts are being made to improve workforce capacity:

- SB 738 pilot projects are testing new models of care, such as training dental health aide therapists (DHATs) and placement of interim therapeutic restorations by dental hygienists.
- The number of expanded practice dental hygienists (EPDHs) in Oregon has risen from roughly 200 in 2013 to 633 in 2016.
- HB 2024 mandates that traditional health workers (THWs) undergo training as oral health navigators and educators.
- Oregon Health & Science University (OHSU) requires cultural competency training for all third-year dental students.

The *Strategic Plan* suggested developing baselines for workforce capacity. As of 2016, only one baseline figure was available.

Priority Area 2: Outcome Measures	Total	Source
Proportion of underrepresented minority students admitted to dental programs	26.3%	OHSU

Recommendations

- All stakeholders should support efforts to attract and retain a culturally competent and diverse dental workforce.
- Oregon's impending shortage of lab technicians and dental assistants should be addressed immediately. In the future, workforce assessments should happen well before shortages occur.

ORAL HEALTH IN OREGON

Oregon's oral health status has improved significantly since 2014. However, too many Oregonians of all ages and regions still lack access to timely, affordable and appropriate dental care and preventive services.

In 2014, the *Strategic Plan for Oral Health in Oregon* identified three priority areas for optimizing statewide oral health:

- Infrastructure
- Prevention and Systems of Care
- Workforce Capacity

This biennial progress report for 2016 assesses the current state of oral health care in each priority area, highlighting our state's remarkable record of success and innovation as well as work that still needs to be done. It is based on input from 50 stakeholders representing a wide variety of public and private organizations, all of whom generously shared their time, expertise, knowledge and concerns.

Our report finds that state health system transformation and national health care reform have done much to increase access to oral health care and education in Oregon. Innovative projects have sprung up around the state to improve the timeliness, quality, affordability and accessibility of care. Projects now underway range from advanced approaches like teledentistry to programs that build on proven interventions such as parenting education. These efforts have succeeded through tireless work on the part of government leaders, policy experts and dental professionals, but also through the dedication and vision of residents, activists and volunteers who want the best for their children and their communities.

The exceptional diversity, energy and commitment of Oregon's oral health advocates are major strengths. Nevertheless, most stakeholders agree that we still lack a shared, overarching vision that can harness our state's extraordinary vitality and facilitate coordination at every level of our health system. In areas where vision and leadership are lacking, constructive efforts occur in relative isolation and important collaborative opportunities are overlooked. When this happens, it is usually the most vulnerable Oregonians who suffer the most serious health consequences.

The inherent difficulty of working across agencies, fields and disciplines is part of the problem. Further obstacles arise from an ongoing lack of relevant data. The *Strategic Plan* identified data collection and sharing as crucial to health system transformation in general and to oral health in particular. Although real progress has been made statewide and in specific communities, the goal of timely information sharing — including the integration of electronic medical and dental health records — remains elusive. To achieve a truly holistic health care system that meets the medical, dental and behavioral needs of our increasingly diverse population, Oregon's health care advocates, experts and workforce must have timely access to accurate data.

Although a great deal of work remains to be done, the major accomplishments detailed in this progress report should be a source of pride and encouragement to everyone who is striving to improve oral health in our state. We hope that the *Strategic Plan* will continue to inspire and guide these efforts.

Oral Health and Well-Being in Oregon

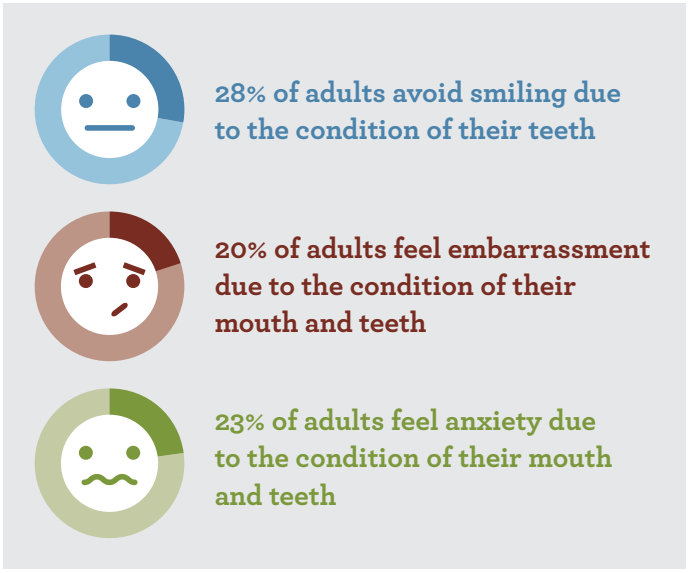


Chart adapted from *Oral Health and Well-Being in Oregon.* American Dental Association, Health Policy Institute, 2016. Used by permission.

Plan History

In 2013, the Oral Health Funders Collaborative of Oregon and Southwest Washington partnered with Oregon Health Authority and the Oregon Oral Health Coalition to produce the *Strategic Plan for Oral Health in Oregon*. Almost 200 oral health advocates representing a wide variety of professional fields, communities and viewpoints took part in this collaborative process. The purpose of the *Strategic Plan* was to guide policymakers, funders, local coalitions and other motivated stakeholders as they work together to improve Oregon's oral health system through 2020. Participants in the development of this plan followed three basic guidelines:

1. Teach Oregonians and policymakers that oral health is inseparable from overall health.
2. Seek diverse perspectives, ranging from community members to oral health professionals.
3. Identify currently actionable community-based strategies that will improve oral health for all Oregonians.

Periodically, the Oral Health Funders Collaborative will sponsor progress reports on the *Strategic Plan*, which will be shared at the Oregon Oral Health Coalition's annual conference. We welcome your comments, updates and suggestions.

PRIORITY AREA 1: INFRASTRUCTURE

Infrastructure comprises all of the interconnected elements of the systems that provide oral health services to Oregonians, including resources, partnerships, and physical and organizational structures.

Summary

Since the *Strategic Plan* was published in 2014, Oregon has seen a concerted effort to build state, regional and local oral health infrastructure and capacity. State actions include hiring a state dental director, improving internal collaboration across agency divisions, and launching an environmental scan of oral health integration. The State Health Improvement Plan (SHIP) has recognized oral health as a priority, and legislative actions have expanded dental access for children and adults.

Over the last two years, organizations around the state have created their own oral health plans, many of which align with the *Strategic Plan*. To foster internal and external collaboration, Oregon Health Authority (OHA) is also developing an oral health plan that will align with both the SHIP and the *Strategic Plan*.

Pediatric dental benefits are now offered on the insurance marketplace through the Affordable Care Act. In addition to reducing the population of uninsured Oregonians, Medicaid expansion is advancing the coordination of medical, dental and behavioral health care in our state. However, Oregon's Medicaid reimbursement rates for fee-for-service dental care vary by CCO. The American Dental Association's Health Policy Institute emphasizes that "states that have implemented reimbursement increases…have seen significant gains in provider participation and access to dental care."

Coordinated care organizations (CCOs) are making progress toward fully integrating oral health, and two incentive metrics for oral health have been established. CCOs have recognized oral health as a priority, and some are accordingly supporting local or regional oral health initiatives. Current and emerging oral health coalitions are contributing valuable community input to these efforts. At the same time, federally qualified health centers (FQHCs) and school-based health centers (SBHCs) have added or expanded dental services in many communities.

Despite Oregon's many successes, there is an ongoing need for shared priorities, clarity of roles, open communication, and coordination between CCOs, dental care organizations (DCOs), community advisory councils, coalitions and other stakeholders. In particular, DCOs face challenges due to a lack of consistent expectations, priorities and metrics.

Action at the State Level

While the hiring of Dr. Bruce Austin as the state dental director (see below) is perhaps the most well known state action on oral health, many other important steps have been taken:

- Oral health is one of seven priorities in the SHIP. Planned strategies include population interventions, such as increasing the number of fluoridated public water districts; health equity interventions, such as providing sealants

SPOTLIGHT ON SUCCESS

In 2014, the *Strategic Plan* noted Oregon's need for a state dental director. In 2015, Senate Bill 672 established the office of dental director by statute within Oregon Health Authority (OHA), and Dr. Bruce Austin was appointed to this vital position. As part of OHA's integrated Clinical Leadership Team, Dr. Austin coordinates oral health activities across the Health Systems, Public Health, and Health Policy divisions. This has improved collaboration and awareness while further integrating oral health with physical and behavioral health systems. To build on this progress, a new cross-divisional Oral Health Team meets monthly. "It's been rewarding to see the vastly increased awareness of oral health across the state system," Dr. Austin says.

Dr. Austin has more than 30 years' experience as a clinical dentist. During his first year as dental director, he met with oral health advocates and stakeholders to build relationships and learn firsthand about their needs. As of 2016, successes include integrating oral health into the State Health Improvement Plan (SHIP), issuing new recommendations to increase dental access for pregnant women on Oregon Health Plan, creating cross-divisional oral health workgroups, and changing the periodicity schedule to allow expanded practice dental hygienists to perform exams in alternative care settings. The office is now working on a strategic plan that will identify gaps and priorities as well as new opportunities for cross-divisional and interagency collaboration and communication.

OHA is also working with community partners to address water fluoridation as outlined in the SHIP, dismantling obstacles to health system integration, and facilitating information sharing with other agencies and partners. "We're working on more efficient ways to keep internal and external stakeholders informed and aware of oral health issues within OHA," Dr. Austin says.

Dr. Austin's current activities include working to modernize rules for teledentistry, expanding OHA's capacity to support oral health research and analysis, creating dental-specific guidelines for the Oregon Opioid Prescribing Guidelines Task Force, and defining protocols for the emergency deployment of medical providers (including the dental workforce) in the event of a major disaster such as an earthquake.

Legislative Action on Oral Health Since 2014

Bill	Summary	Date	Plan Alignment
SB 474	Allows certain nonprofit charitable corporations to own and operate dental clinics that serve children with special needs.	6/11/15	Priority Area 1
SB 672	Established the office of state dental director within OHA.	6/11/15	Priority Area 1
HB 2972	Requires children 7 and younger to have a dental screening on entering public school.	6/25/15	Priority Area 2
HB 2024	Directs OHA to adopt rules and procedures for training and certifying certain health workers to provide oral disease prevention services.	6/25/15	Priority Area 3
SB 606	Extends SB 738 for 7 years. SB 738 allowed OHA to approve pilot projects to encourage the development of innovative practices in oral health care delivery systems, including alternative workforce models.	7/1/15	Priority Area 2 Priority Area 3
HB 3464	Ensures that pregnant women with fee-for-service Medicaid coverage have timely access to dental care by creating parity with existing standards for the CCO population.	7/21/15	Priority Area 1
SB 660	Requires that local school-based sealant programs be certified by OHA.	7/27/15	Priority Area 2

in schools and ensuring that Oregon has an adequate supply of oral health professionals; and health systems interventions, such as increasing early preventive care for children and including oral health in chronic disease prevention and management.

- As part of the Maternal & Child Health Title V block grant, OHA funds oral health activities for Douglas, Jackson, Klamath, Marion, Multnomah, Wallowa and Washington counties, and for the Coquille and Cow Creek tribes.
- OHA has expanded Oregon Health Plan (OHP) coverage to include the D0191 dental assessment code in medical settings for children under 6. The service includes risk assessment and anticipatory guidance. Coverage is contingent on providers receiving training through *First Tooth* or *Smiles for Life*. Some CCOs are voluntarily extending this coverage to all children 19 and under.
- OHA has expanded the OHP dental benefits package for all adult populations. As of July 2016, these benefits include dentures, denture replacement and stainless-steel crowns.

Coordinated Care Organizations (CCOs)

As of July 2014, all CCOs had contracted with participating DCOs in their region. Currently, Oregon has a total of 16 CCOs and nine DCOs.

The CCO model is improving access to oral health data, and CCOs are gaining valuable knowledge from dental health integration. Although they are still in their early stages, CCOs have already improved the tracking of quality metrics for dental care and integrated oral health metrics into overall health metrics. This is helping to create a unified platform for sharing data.

As of 2016, two CCO incentive metrics relate to oral health: sealant rates, and children under Department of Human Services (DHS) custody having a physical, oral and behavioral health assessment within 60 days. OHA is currently incorporating these metrics into the Oregon Oral Health Surveillance System.

Some CCOs have awarded funding to DCOs that achieved the sealant metric. The DCOs can then use these funds for such activities as chronic disease management. The CCO-DHS metric requires coordination between physical, mental and dental health care, which serves as a foundation for further integration.

CCOs have also been instrumental in forming partnerships that expand oral health access. For example:

- AllCare CCO has embedded employees with Josephine County Public Health and intends to partner with them to open a dental clinic at the new public health building. AllCare is also integrating oral health priorities into SBHCs and primary care settings, and enlisting oral health providers in the effort to reduce opioid abuse.
- Kaiser Permanente and Providence Health & Services are partnering to build dental capacity at community clinics. In Portland, they are supporting expansion of the Creston Dental Clinic. In the Salem area, they are supporting volunteers who screen and refer patients to Kaiser clinics for free dental care. They also support Adventist Health's effort to add dental care at a new community-based clinic.

Quality metrics

As CCOs define dental strategy and service level agreements (SLAs) with DCOs, the need for consistent, systemic quality metrics is coming to the fore. To date, metrics have differed from one CCO to the next, leaving DCOs in the difficult position of trying to comply with varying standards and expectations.

To address this issue, CCO Oregon has convened a workgroup of dental professionals and CCO administrators to develop quality metrics that will align with measures recognized by the

Dental Quality Alliance while also supporting Oregon's Triple Aim of *better care*, *better health* and *lower costs*. Adopting these metrics will ease the administrative and cost burdens that DCOs currently face while also giving CCOs flexibility to create SLAs with metrics that are relevant to their membership.

Alternative payment methodologies (APMs)

Implementing APMs is central to the goals of health system transformation. As opposed to the volume-based fee-for-service (FFS) model, value-based APMs utilize incentives and quality metrics to create a coordinated, team-based model of care that fosters accountability by rewarding performance and outcomes.

The variety of payment models has made it difficult to align metrics across DCOs. Currently, CCOs are paying DCOs capitation (a fixed payment for annual services per patient). Dental plans generally reimburse providers or provider networks through the FFS model. Some CCOs have implemented capitation or pay-for-performance programs that are tied to performance measures or that share incentive dollars for meeting dental metrics. As noted above, CCO Oregon's quality metrics are intended to align dental APMs with the Triple Aim.

CCOs and DCOs are discussing expanding APMs in 2017; options include value-based purchasing or paying for specific outcomes. Effective APMs will require fully integrated care coordination and should incentivize DCOs to achieve Triple Aim outcomes.

Building Coalitions

Local oral health coalitions are a vital part of Oregon's state and regional health infrastructure. Since 2014, the Oregon Oral Health Coalition (OrOHC) network has expanded from six to 11 coalitions. New and emerging coalitions include Columbia Gorge (Hood River and Wasco counties), Southern Oregon (Jackson and Josephine counties), South Coast (Coos and Curry counties), Eastern Oregon (Morrow, Umatilla and Union counties), Klamath County and Douglas County.

These groups are broadening the base of active oral health stakeholders and serving as a unified voice for advocacy. Many coalitions have completed regional needs assessments and are aligning local objectives with the *Strategic Plan*. They are also working in tandem with CCOs and DCOs to achieve statewide objectives and strategies in their communities.

Building Capacity

The *Strategic Plan* advocated expanding oral health services through FQHCs and SBHCs. Today, more SBHCs than ever are providing these services. In the 2014-15 school year, six SBHCs saw 265 clients for a total of 462 dental visits. In 2015-16, 14 SBHCs served 1,083 clients over 1,670 visits. The SBHC at Central High School in Independence served 354 children over 781 visits.

Although more SBHCs are providing dental care, the model of care varies. Thus, an opportunity exists to increase coordination with the rest of the dental care system. As part of the SHIP, the state SBHC program is working with OHA to integrate oral health into adolescent well-child visits and sports physicals.

FQHCs are also expanding oral health services. In 2016, the U.S. Health Resources and Services Administration (HRSA) funded the expansion of four FQHC dental clinics: La Clinica del Valle in Medford, Mosaic Medical in Prineville, Neighborhood Health Center in Portland, and the Wallace Medical Concern in Portland.

Health System Integration

Health system transformation entails full integration of dental, medical and behavioral care and data. Although a good deal of progress has been made since 2014, primary care providers need deeper education and engagement, more coordinated oral health messaging and better support with dental navigation. At the same time, dental office teams need to take advantage of opportunities to gain a better understanding of behavioral health and to collaborate with primary care providers on chronic disease prevention and management.

The Oregon Primary Care Association is convening FQHC dental and medical directors so that they can learn more about each other's work and identify opportunities for integration. Also, CCO Oregon's dental workgroup is developing a framework that measures integration along a continuum from cooperation to co-location to full integration, taking into account not only the degree of coordination across systems, but also the degree to which care is patient-centered (i.e., tailored to patient needs and based on shared responsibility between patients and caregivers).

The *Strategic Plan* recommended integrating electronic medical and dental health records to improve care coordination. As of 2016, integration of electronic records remains poor. However,

SPOTLIGHT ON INNOVATION

Some CCOs and DCOs are using data from the PreManage reporting system to follow up with patients who have been seen in a hospital emergency department (ED) for nontraumatic dental problems. This is important because even patients who have dental coverage may have difficulty understanding how, when and where to access dental care. Often, such patients wait until oral health problems become acute and then seek care in an ED. PreManage notifications serve as an alert that dental plan members need assistance, giving providers an opportunity to connect them with a dental home. As an example, CareOregon Dental reaches out to members who have recently visited an ED for tooth pain and offers them assistance with finding a dental home and overcoming barriers to access such as lack of transportation. They also notify the dental office to contact the member about scheduling an appointment. This system reduces costly ED visits while guiding vulnerable patients toward appropriate care and support.

a number of providers are implementing Epic / Wisdom health record software, which will move them toward full integration. Until all providers can access integrated health records, Oregon's progress toward true care coordination will be hampered.

Data Collection and Access

As of this writing, OHA does not have adequate support or funding for expanded surveillance or for a database that tracks preventive services. Neither a statewide registry nor county-level data collection will be possible without additional funding and legislative direction. There is also a need to define which data can be collected and shared under statutory and confidentiality restrictions, and to conduct an inventory of existing data sources to identify gaps, opportunities and potential linkages.

In May 2016, the Medicaid Advisory Committee convened a workgroup comprising CCO and DCO representatives, dental care providers and other experts to identify factors that influence oral health access for OHP members. Based on its research, the group created an Oral Health Access Framework that considers access in terms of *population factors* (such as member awareness and understanding of benefits), *availability* (potential to access services), *utilization* (use of services), and *structural/systems of care* (policy and systems issues that affect availability and utilization). The Framework includes a Monitoring Measures Dashboard to track access indicators for OHP members.

CCOs and other stakeholders are also taking steps to improve data collection. For example:

- CareOregon CCOs are conducting a dental patient satisfaction survey and are also launching a pilot survey of unengaged members to uncover barriers to access.
- PacificSource is investing resources to expand oral health analytics and reporting capabilities.
- Oregon Dental Service has implemented a practice management system for Kemple Memorial Children's Dental Clinic in Central Oregon, allowing them to capture encounter data and provide school-specific reporting.
- The American Dental Association's Health Policy Institute has generated state-specific benchmarks for key data such as coverage, utilization, workforce, and consumer attitudes.

In addition to a lack of data, especially at the community level, barriers to sharing existing data are an ongoing problem. In particular, CCOs and community partners need to take better advantage of online information-sharing tools such as listservs.

Emergency department (ED) utilization data

The *Strategic Plan* challenged Oregon to create "a reporting database that tracks hospital emergency visits for nontraumatic dental problems" by 2017. In 2015, the Emergency Department Information Exchange (EDIE) was adopted by all 60 Oregon hospitals, enabling them to receive real-time notifications of ED and inpatient visits in Oregon and Washington. PreManage is a companion system that extends these notifications to CCOs, health plans and primary care offices.

In addition to monitoring the cost of dental ED visits, tracking ED use is forging stronger partnerships between EDs and DCOs on emergent needs (see *Spotlight,* page 7). In 2017, improved statewide and regional reporting will track the total number of patients seeking ED care for nontraumatic dental problems, allowing stakeholders to monitor progress while also gathering in-depth data to guide improvement efforts.

Priority Area 1: Outcome Measures	Target	Status
Oregon has an appropriately staffed, funded and empowered dental director per ASTDD best practices.	2015	In Process
OHA develops a strategic plan to improve and expand Oregon's oral health surveillance system.	2015	In Process
OHA's oral health program is adequately funded to implement the activities outlined here and in the Public Health Division's health improvement plan, and to meet ASTDD guidelines for state oral health programs.	2016	In Process
OHA Metrics and Scoring Committee adopts comprehensive metrics for oral health.	2016	In Process
Oral health coordinators serve each county through public health departments, nonprofits and other entities.	2016	In Process
CCOs have comprehensively integrated oral health as described in *Infrastructure Objective 2, Strategy 1* (see page 1).	2016	In Process
Oregon's Centers for Medicare & Medicaid Services oral health program resolves discrepancies in billing and reimbursement practices described in *Infrastructure Objective 2, Strategy 3* (see page 1).	2016	In Process
Oregon has a reporting database that tracks hospital emergency visits for nontraumatic dental problems.	2017	Completed
Health information systems include detailed data on race, ethnicity, language and other characteristics necessary to monitor oral health equity as required by state law.	2017	In Process
All school-based health centers (SBHCs) integrate oral health care into their activities.	2018	In Process
All federally qualified health centers (FQHCs) integrate oral health care into their activities.	2018	In Process

PRIORITY AREA 2: PREVENTION & SYSTEMS OF CARE

Evidence-based behavioral and policy interventions will reduce the toll of oral diseases and achieve a high lifelong standard of oral health for all Oregonians, regardless of income, background or location.

Summary

Since 2014, oral health efforts in Oregon have focused mainly on prevention and systems of care, especially for pregnant women and children. Many innovative programs have targeted this population, including co-location of dental professionals in non-dental settings and integration of oral health assessments and anticipatory guidance in medical settings. Where data are available, they tend to show progress toward the outcome measures set forth in the *Strategic Plan*. However, there is little evidence of systematic collaboration, coordination and sharing of best practices. This may be leading to duplication of effort.

Oregon is one of only 13 states to offer comprehensive oral health care benefits for the adult Medicaid population. Despite this, care for underserved adults — especially seniors, who lack dental benefits under Medicare — remains inadequate, as does care for people with special needs or low socioeconomic status. For the general population, efforts relating to adult oral health — including integrative care management for people with chronic diseases — have been limited. Although some organizations have effective programs for vulnerable adults, the need for accessible and affordable adult services remains urgent.

Water Fluoridation

Community water fluoridation remains the most cost-effective method of improving public oral health and achieving oral health equity. Despite its proven safety and efficacy, it has been politically contentious in many Oregon communities. Since 2014, Oregon's main successes in regard to water fluoridation have involved defending existing programs. The Oregon Public Health Association's Oral Health Section deserves particular commendation for its strong advocacy in Newport, Lebanon and Coquille (see *Spotlight*, page 10).

Even though the current climate is not conducive to a broad legislative initiative, supporting water fluoridation is still crucial. It is a priority in the SHIP, and community advocacy will continue in future legislative sessions. Advocates believe that success will most likely result from a long-term communication strategy that emphasizes the science, especially state-level data (e.g., children who need hospital operations for severe caries in communities with and without water fluoridation).

Cultivating health care professionals and other knowledgeable individuals as advocates would be helpful, as would connecting with advocacy groups to advance the conversation about the proven benefits of water fluoridation for Oregonians of all ages.

Several CCOs have developed a letter endorsing community water fluoridation as a major public health priority. This presents an important opportunity for water fluoridation advocates to be visibly engaged and supportive.

Maternal Oral Health

Since 2014, the number, quality and variety of programs serving pregnant women have increased substantially. At the state level, OHA's Oral Health Unit is integrating oral health into the Maternal & Child Health (MCH), Health Promotion, and Chronic Disease Prevention programs. As part of the Title V MCH block grant, seven county health agencies and two tribes are working to increase dental visits for pregnant women and children.

OrOHC's *Maternity: Teeth for Two* program promotes dental visits by pregnant women, both to improve their own health and to decrease their babies' risk of dental caries. OrOHC works with CCOs and medical clinics to integrate education, assessments, referrals and navigation into dental visits. Similarly, Virginia Garcia Memorial Health Center's *Centering Pregnancy* offers group-based prenatal care with a strong oral health component.

In a striking example of innovation, some dental clinics are incorporating *One Key Question*, which is a statewide initiative to reduce unplanned pregnancies. These clinics also provide reproductive health resources.

A number of CCOs are offering pregnant women incentives to choose healthy behaviors and to attend medical and dental appointments. As an example, Jackson Care Connect gives pregnant women a voucher they can use at a CCO store that stocks items such as diapers and formula. InterCommunity Health Network CCO and Capitol Dental have similar programs.

Access is also expanding through dental vans, teledentistry and co-location projects. Examples include Samaritan Health Services' *Healthy Smiles for All* initiative and Providence Health & Services' partnership with Medical Teams International (MTI) to offer dental van services at maternity clinics (see Priority Area 3).

Infants and Children

Oregon's preventive efforts mainly target infants and children, and these efforts often entail medical-dental integration. For example, OrOHC's *First Tooth* program trains medical and dental providers to deliver preventive care to children 0 to 6. In 2014, OrOHC shifted to a capacity-building "train the trainer" focus. As of 2016, 36 trainers have trained 1,300 medical, dental and educational providers and caregivers. OHA originally developed *First Tooth* and promotes it to statewide partners.

All of Samaritan Health Services' clinics have implemented *First Tooth* since 2010, and Providence Health & Services plans to train all providers in 20 clinics by the end of 2017. Yamhill CCO reports that most local pediatric providers have completed *First Tooth* training and are providing screenings and fluoride varnish. Jackson Care Connect and Columbia Pacific CCOs are currently incorporating *First Tooth* along with dental referrals for pregnant

SPOTLIGHT ON SUCCESS

In April 2015, Oregon Drinking Water Services checked Coquille's water system and found no trace of fluoride, even though the system had been fluoridated for more than 30 years. Concerned, the Oregon Public Health Association's Oral Health Section reached out to the town's largest dental office.

When Dr. Herman Pahls learned that his town's water was no longer fluoridated, he contacted the local water department only to find that the head of the public works department had unilaterally discontinued fluoridation after conducting personal "research" at various anti-fluoridation websites. Having made this poorly informed decision, this city employee also chose not to inform the mayor or the local medical and dental community that the water fluoridation system had been shut down.

After Dr. Pahls informed Coquille's mayor that fluoride was no longer being added to the community's water system, the mayor put water fluoridation on the agenda for the next city council meeting and invited Dr. Pahls as a local advocate. In preparation for the meeting, the Oral Health Section sent Dr. Pahls a fluoride factsheet and advised him not just to detail his professional experience with the benefits of fluoride, but also to express his dismay that a single city employee could put an end to the program without notifying anyone.

The city council meeting was a success. Two weeks later, the Oral Health Section received a thankful email from Dr. Pahls' office, informing them that fluoridated water was once again flowing from the taps in Coquille. This story shows that water fluoridation battles can be won and that building connections between public and private advocates is crucial to a good outcome.

women into primary care. This training emphasizes developing effective workflows; trainers monitor trainee progress, providing further instruction and assistance as needed. They also monitor DCO referrals to ensure that primary care patients are receiving prompt treatment.

In partnership with CCOs, providers are targeting underserved children through WIC, Head Start, K-12 and migrant programs. Services include screenings, varnish and x-rays. Oregon's Dental Home Initiative aims to make sure all Head Start programs offer assessments and varnish. In Central and Eastern Oregon, Advantage Dental is also serving youth in addiction centers, behavioral health programs, and relief nurseries. In addition, the longstanding Tooth Taxi dental van program partners with schools to provide onsite services for children.

Dental3 (D3) was formed in December 2014 as a partnership of Medicaid dental plans, CCOs and community partners in the Portland area. Its aim is to advance health system transformation by furthering oral health through the provision and coordination of preventive services in alternative settings. Although currently focused on Medicaid children, D3 plans to expand services to the general population. D3 has also developed a data-gathering system to track services and outcomes.

Dental screenings

HB 2972 (2015) requires all children 7 and younger to have a dental screening on entering public school. Because reporting is not mandatory, this bill may be revised in the upcoming legislative session to mandate reporting measures developed by the Association of State and Territorial Dental Directors and used by almost 40 other states. Also, dental screenings per se are not an evidence-based practice; they must be followed by an appropriate intervention such as sealants, fluoride varnish or a dental visit. Addressing these fundamental issues will strengthen the bill.

Many CCOs are working with DHS to facilitate dental screenings for children in DHS custody per the CCO-DHS screening metric, so that these children can receive one-stop medical, dental and mental health screenings through DCOs.

Advantage Dental's PREDICT (Population-Centered, Risk-Based, Evidence-Based, Dental Interprofessional Care Team) project serves low-income pregnant women and children through community-based sites in Coos, Deschutes, Douglas, Jackson, Josephine, Klamath, Morrow and Wasco counties. PREDICT uses expanded practice dental hygienists (EPDHs) to screen clients for low, moderate and high risk of oral diseases. Low-risk clients receive fluoride toothpaste and preventive education. Moderate- and high-risk clients may also receive silver diamine fluoride, betadine/fluoride varnish, sealants, or glass ionomer temporary restorations; high-risk clients get more intensive care and case management. The University of Washington is evaluating this project and will compare outcomes with those of populations in seven control counties.

Sealant programs

In 2012, Pew Charitable Trusts gave Oregon a B grade for its statewide sealant program. In 2015, the state received an A-, scoring 11 out of 11 points on sealant measures. Oregon was one of only three states to receive this rating. The minus grade was due to the fact that "Medicaid managed care organizations do not yet reimburse the statewide sealant program." Since then, the statewide program has shifted nearly half of its schools to local certified programs, which has improved the capture of sealant data for the Medicaid population.

OHA's statewide sealant program serves schools in which 40 percent or more of the students are eligible for free or reduced-price lunches. (In 2014, the cutoff level was 50 percent.) The program materials are currently available in seven languages: Spanish, Arabic, Hmong, Russian, Simplified Chinese, Somali

and Vietnamese. In the 2014-15 school year, 6,600 children were screened and 4,721 received sealants.

Other certified sealant programs operate in 35 of Oregon's 36 counties. Some examples follow:

- Capitol Dental provides sealants in 115 schools. In 2015-16, they screened 5,466 students and sealed 3,696.
- *Ready to Smile* serves K-8 children in Coos and Curry counties through a partnership with Advantage Dental. In 2015-16, the program visited 21 schools, screening 4,876 students and placing 3,241 sealants.
- Eastern Oregon CCO partners with Advantage Dental to provide sealants to an estimated 2,500 children, many of whom live in areas with few or no dental services.
- Kemple Clinic provides sealants in Redmond and Sisters in partnership with Advantage Dental. As of summer 2016, they have screened 6,000 children and sealed 1,300.
- Multnomah County's sealant program screened 4,796 students and sealed 3,178 in the 2015-16 school year.

In 2015, SB 660 required that all local school-based sealant programs be certified by OHA. This ensures quality services and improves statewide coordination. Every OHA-certified sealant program must collaborate with area CCOs and bill Medicaid. Therefore, they must have contracts with DCOs. The one-time certification training also entails establishing a referral system.

Also in 2015, D3 established a Tri-County Sealant Workgroup to develop a coordinated plan for evidence-based sealant delivery through schools in Clackamas, Multnomah and Washington counties. D3 has also collaborated with Head Start coordinators and the Tri-County Dental Home Initiative team to ensure that all eligible children enrolled in a tri-county Head Start program receive dental screenings and fluoride varnish three times a year.

Although sealant programs have expanded greatly since 2014, children with special needs and behavioral issues are still less likely than their peers to receive sealants. Glass ionomer sealants may be a simpler, less invasive alternative for this population. Other challenges include cultural and language barriers and lack of parental consent. Many programs are working with schools to increase the rate of parental consent. As part of this effort, AllCare CCO has created a public service announcement to promote permission slip return (*https://youtu.be/B05yUvmYGCc*).

Patients with Special Needs

People with special needs often have an elevated risk of dental disease, particularly when sensory or behavioral issues make traditional dental appointments difficult. Appropriate dental services for children with special needs are scarce, especially for patients outside urban areas. A few dentists offer services for this population, as do some larger providers such as Providence Specialty Pediatric Dental Clinic and Exceptional Needs Dental Services, but access is often limited or unavailable. Furthermore, dental insurance plans do not cover behavioral interventions that help children tolerate dental procedures without sedation or mechanical restraint. Once these children become adults, there are even fewer options for care.

An innovative effort is being spearheaded by Dr. Raji Mathew of Capitol Dental in McMinnville, who completed a clinical fellowship program at the University of Washington School of Dentistry in dental care for people with disabilities. Through a partnership between Capitol Dental and Yamhill CCO, the Integrated Behavioral-Dental Healthcare (IBDH) project will deliver specialized preventive services and case management to an estimated 750 Yamhill County residents who typically lack access to oral health care, including children with special needs and adults who face functional, medical or behavioral challenges. The goal is to develop protocols for the integration and coordination of care among behavioral and dental health providers, as well as an improved case management system that supports timely care for members with special needs.

An IBDH team comprising Dr. Mathew and a specially trained dental hygienist and dental assistant will serve patients at Evans Street complex in McMinnville, Yamhill-Carlton Elementary School and Amity Elementary School. They will also serve a special-needs preschool population. The project has a referral component to track follow-up care, and it will generate baseline data to support strategic planning for utilization management.

Underserved and High-Risk Adults

In 2014, the *Strategic Plan* emphasized the need to provide underserved adults with community outreach, prevention, intervention and education. Unfortunately, Oregon still lacks resources for underserved adults, especially seniors, veterans, people in poverty, people with chronic diseases, and people with behavioral issues. Undocumented, homeless and geographically isolated populations often lack access to oral health care, and efforts to improve access run the risk of overwhelming the system's current capacity. Available services tend to be part of a patchwork approach that focuses on acute needs (e.g., treating abscesses or pulling teeth), as opposed to connecting patients with a dental home that provides ongoing education, care and support.

One promising approach has been implemented by Providence Health & Services, which is partnering with MTI to provide 130 annual dental van days at Providence locations and community sites. Providence staff are providing underserved and uninsured patients with referrals to MTI vans or clinics. This addresses the patients' immediate needs while also connecting them to a dental home. To date, dentures are the most commonly reported patient need.

The *Strategic Plan* also stressed the necessity of integrating oral health with chronic disease prevention and management. Several groundbreaking projects are now underway:

- Trillium CCO in Lane County has provided grant funding to Willamette Dental Group for a program that will use evidence-based dentistry to manage dental disease in 500 adult members with diabetes or high-risk tobacco use. The project will use the *Smiles for Life* curriculum to reduce

SPOTLIGHT ON SUCCESS

In 2014, The Oregon Community Foundation (OCF) launched the five-year Children's Dental Health Initiative to address the statewide crisis of childhood dental disease. The Initiative calls for a three-pronged approach: Fund efforts to raise awareness, coordinate and provide preventive services, and advocate for policy reform.

Several partners have joined OCF in providing grants for 15 community-based organizations to deliver a comprehensive dental health promotion program at regional elementary and middle schools. Together, OCF and its partners — A-dec, The Collins Foundation, The Ford Family Foundation, Kaiser Permanente, Meyer Memorial Trust, Northwest Health Foundation and Providence Health & Services — are investing more than $3.5 million in this initiative. Nine grantees are working to expand existing services and six have received funding to launch new programs in previously unserved schools. All grantees are expected to develop sustainable models by coordinating services with CCOs, DCOs and OHA. In the 158 schools served by expansion grantees in the 2015-16 school year, 13,366 screenings were conducted, 23 percent of which found untreated decay.

patients' oral health risk score. Patients will be tracked to determine their initial risk and to assess outcomes. Success will be validated through outcomes-based medical and dental coordination.

- Columbia Pacific CCO will provide dental screenings for patients with comorbid conditions such as diabetes.
- Capitol Dental's planned co-location site at a Lebanon Surgicenter will serve diabetics and pre-op total joint patients in addition to children and pregnant women.
- Kaiser Permanente dental clinics now address medical care gaps (e.g., a colonoscopy or mammogram) at dental appointments. These clinics have been Kaiser's most successful means of promoting adult preventive services.
- One Community Health is conducting a pilot with physicians who provide oral health assessments and streamlined dental referrals for diabetics.

As new technologies and medical-dental integration advance, opportunities will also arise to expand screening protocols such as hemoglobin A1c (HbA1c) testing for diabetics and salivary testing for oral cancers.

Communities of color

The diversity of Oregon's population is increasing, but culturally and linguistically appropriate dental care for communities of color and non-English-speaking families is not keeping pace with this demographic shift. A 2016 report by Pew Charitable Trusts notes that "communities of color have much higher rates of tooth decay and tooth loss and fewer dental visits and preventive treatments than white populations." In particular, "American Indian and Alaska Native children have the highest rates of untreated tooth decay."

Addressing this problem will require the workforce adaptations recommended in *Priority Area 3: Workforce Capacity*. It will also require consistent engagement, inclusion and relationship building with advocates who serve specific communities of color and who understand their prevailing cultural attitudes, risk factors, trusted knowledge sources, and challenges relating to oral health.

Seniors and their caregivers

In May 2016, Oral Health America's *A State of Decay* report gave Oregon a rating of "poor" for senior oral health, ranking it 29th among the states. Although this is an improvement over the 2013 report, in which Oregon ranked 39th, oral health care for seniors remains a significant service gap. The *Strategic Plan* recommended the following strategies:

- Educate senior care providers on oral hygiene and oral disease risk factors.
- Provide on-site dental care in nursing homes and in assisted living facilities.

Some stakeholders noted that EPDHs could be deployed to accomplish both of these goals. This approach is currently being taken by Providence ElderPlace, which has co-located an EPDH to provide preventive care for frail elderly patients.

Training caregivers at senior facilities is another logical approach. In 2015, OrOHC trained staff at assisted living facilities on the oral health needs of seniors. A total of 265 caregivers from 10 facilities participated, and 821 residents received services. All facilities reported an improved capacity to provide daily oral health care to residents. If expanded, this program could do much to improve oral health in such facilities.

Teledentistry and mobile units are other promising options for reaching underserved seniors. For example, MTI is considering the purchase of specially designed vans to serve senior facilities. Also, Kaiser has participated in and funded a program to provide free dentures to uninsured individuals and Medicaid patients. Services are provided via Oregon Health & Science University (OHSU) School of Dentistry's Russell Street Clinic, with dental students acting as navigators.

Expanding Oral Health Literacy

Oral health education needs to be an integral part of health education across the lifespan. Parenting education needs more discussion of oral health topics, and DHS should include oral health education in training and information for foster parents. Education is also important for nonprofits and volunteers who

deal with public health issues. The following education programs are currently planned or underway:

- The Oregon Parenting Education Collaborative (OPEC) is working with the Oregon Research Institute and others to develop a behaviorally based multimedia oral health curriculum for OPEC-sponsored parenting education classes and home visit programs at Head Start and Early Head Start. In 2016, a pilot was offered to 41 parents in Madras, Harrisburg, Klamath Falls and Monmouth.
- The Coast to Cascades Community Wellness Network, a coalition of regional health care leaders, has launched an HRSA-funded educational campaign promoting dental care in Benton, Lincoln and Linn counties.
- Advantage Dental is working with Early Learning Hubs to integrate oral health literacy. They participated in developing an integrative growth chart that includes behavioral health, oral health and immunizations. They also promote the American Association of Pediatrics' *Brush, Book, Bed* program and provide books to children at every visit. This is an exciting example of the potential for adding oral health education to allied public health projects.
- MTI is surveying adults about barriers to dental care in order to create an adult information program.
- Willamette Valley Community Health CCO is working with Capitol Dental on an in-home program called *Reach, Teach and Restore*, which targets parents whose children had dental problems requiring sedation. The program offers education to prevent the same problems in siblings.
- As part of HB 2972, the school screening bill, OHA has developed a preventive dental care brochure for parents and guardians. The brochure is now available in seven languages.
- The Tooth Taxi program includes oral health education.
- Western Oregon Advanced Health CCO is partnering with AllCare CCO to develop consistent, region-wide oral health messaging in Southern Oregon.

Risk awareness

Major risk factors for oral disease include poor diet and tobacco use. Oregon is currently implementing campaigns on childhood obesity, childhood nutrition, and tobacco cessation. Because these topics are intimately connected with oral health, the dental community must be publicly visible and engaged in this work.

One possible area for engagement is the legislative effort to regulate the sale of junk foods in schools. Oregon has been the only state to prohibit restrictions on the marketing of sugary drinks and junk foods in schools on free speech grounds. Federal legislation that supersedes state law would allow for stronger state administrative rules on junk food marketing in schools. This would be a crucial public health campaign for Oregon's oral health advocates to inform and support.

Priority Area 2: Outcome Measures	Baseline	Current	2020 Target	Target Change	Current Change
Population residing in communities with optimally fluoridated water	22.6%	22.2% [1]	25%	10% ↑	-1.8% ↓
Pregnant women who had their teeth cleaned within the previous year	53.2%	58.3% [2]	58.5%	10% ↑	9.6% ↑
Children 0 to 5 with a dental visit in the previous year	—	42.8% [3]	47.1%	10% ↑	—
Third graders with decay experience	58% [4]	—	52.2%	10% ↓	—
Children ages 6 to 9 with sealants on one or more permanent molars	38.1% [4]	—	41.9%	10% ↑	—
Individuals who have received First Tooth training	3,046	4,398 [5]	8,000	162% ↑	44.3% ↑
Eighth graders with decay experience	70.1%	68.7% [6]	63.1%	10% ↓	2.0% ↓
11th graders with a dental visit in the previous year	74.5%	74.9% [6]	81.2%	10% ↑	0.5% ↑
Adults 18 and older with a dental visit in the previous year	63.8%	67.0% [7]	70.2%	10% ↑	5.0% ↑
Percentage of new HPV-associated cancers that are oral and throat cancers	40.9% [8]	—	—	—	—
ED utilizations for nontraumatic dental problems	2.0% [9]	—	1.8%	10% ↓	—

1. Oregon Oral Health Surveillance System: Oregon Drinking Water Services, 2014. Baseline is from 2012.
2. Oregon Oral Health Surveillance System: Pregnancy Risk Assessment Monitoring System (PRAMS), 2013. Baseline is from 2011.
3. Current (2015) figure from Medicaid administrative claims data, OHA Office of Health Analytics. This figure replaces the baseline in the original *Strategic Plan* both to provide a more accurate proxy for the 0-5 population and to align with Oregon's *State Health Improvement Plan, 2015-2019*.
4. Oregon Health Authority, *Oregon Smile Survey*, 2012.
5. Oregon Oral Health Coalition data as of November 2016.
6. Oregon Health Authority, *Oregon Healthy Teens Survey,* 2015. Baseline is from 2013.
7. Oregon Oral Health Surveillance System: Behavioral Risk Factor Surveillance System (BRFSS), 2014. Baseline is from 2010.
8. Oregon State Cancer Registry (OSCaR), 2009.
9. Benjamin Sun and Donald L. Chi, *Emergency Department Visits for Non-Traumatic Dental Problems in Oregon State*, 2014.

PRIORITY AREA 3: WORKFORCE CAPACITY

To meet Oregon's growing oral health needs, we must bolster workforce capacity through innovative strategies to recruit, train, retain and equitably distribute oral health care providers throughout our state.

Summary

In 2014, oral health workforce shortages were an issue of serious concern. Although OHP had expanded dental benefits, the lack of access to providers remained a major barrier to receiving care. Two years later, these problems not only persist but are likely to intensify, especially for lab technicians and dental assistants. This is not simply due to a lack of providers; it also stems from inequitable distribution, especially in rural areas.

In response, major efforts to expand workforce capacity are underway. SB 738 has enabled pilot projects to test new models of care such as training dental hygienists to place interim therapeutic restorations and deploying dental health aide therapists (DHATs) to serve Native communities.

EPDHs are increasingly serving in community settings through contracts with DCOs such as Advantage Dental and Capitol Dental. However, they face persistent challenges relating to reimbursement. The dental workforce has also been expanded by HB 2024, which requires that traditional health workers (THWs) who help underserved communities access health care be trained as oral health navigators and educators. CCO Oregon's dental workgroup and the oral health integration project conducted by Health Management Associates for OHA both align well with these efforts.

Since 2014, community-based site rotations for dental students have increased from 14 days to a minimum of 25 days, and interprofessional programs are encouraging multidisciplinary collaboration between students while also educating them on the social determinants of health (see *Spotlight* below). Incentives for rural providers have expanded as well.

The *Strategic Plan* suggested outcome measures for workforce capacity, but no baseline data were available at the time of publication. As of 2016, only one baseline figure is available: OHSU reports that in the 2015-16 academic year, 26.3 percent of students admitted to dental programs were members of an underrepresented minority group. Other suggested baseline figures for workforce capacity are expected to become available in coming years. For example, data on cultural competence training will be reported to OHA beginning in 2017.

Workforce Shortages

In 2014, the number of licensed dentists working in Oregon climbed from 2,335 to 2,562, an increase of 10 percent over 2012. However, this increase masks decreases in specific regions. For example, dentists in Eastern Oregon have declined by about 5 percent since 2010. During the same time, the number of dental hygienists decreased by 9 percent from 2,371 to 2,153. Currently, more than 1 million Oregonians — or 31 percent of the population — live in a federally designated dental health professional shortage area (HPSA), defined as an area with 5,000 or more people per dentist. This is an increase over the figure of 944,000 (24 percent) reported in the *Strategic Plan*.

A looming shortage of lab technicians and dental assistants will have a serious impact on our state if not addressed immediately. Stakeholders agreed that in the future, workforce assessments should happen well before shortages occur.

Pilot Projects for Workforce Development

In 2011, SB 738 authorized OHA to administer pilot projects for alternative oral health workforce models. In 2015, SB 606 extended this program for seven years. As of 2016, OHA has approved two pilot applications:

- **Oregon Tribes Dental Health Aide Therapist (DHAT) Project.** This program targets underserved tribal

SPOTLIGHT ON INNOVATION

The Interprofessional Care Access Network (I-CAN) is a three-year project funded by the U.S. Health Resources and Services Administration as part of the OHSU Interprofessional Initiative. In this innovative program, dental, medical, physician assistant, pharmacy and nursing students who are performing existing community/clinic rotations work together to develop interprofessional practice and education partnerships that benefit underserved communities.

Participating students collaboratively develop a multidisciplinary, community-based, patient-centered plan of care that includes addressing the social determinants of health (i.e., the conditions in which people are born, grow, live, work and age). Through this process, students gain a deeper understanding of the social context of vulnerable, disadvantaged and socially isolated patients who have complex health needs, and they also learn the value of collaborative health care in meeting these needs.

As of 2016, there are four I-CAN communities: Klamath Falls, Portland Old Town, Southeast Portland, and West Medford. Klamath Falls participants also enroll in an interprofessional education course and collaborate to meet a specific health need identified by the community.

SPOTLIGHT ON INNOVATION

In response to the *Strategic Plan*'s call for "a culturally and linguistically diverse dental workforce with expertise in reaching and serving disadvantaged populations," Advantage Dental is implementing the following National Standards for Culturally and Linguistically Appropriate Services (CLAS): 1. "Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis," and 2. "Communicate the organization's progress in implementing and sustaining CLAS to stakeholders, constituents, and the general public."

To support these goals, Advantage provides employees with in-person and online training on poverty, implicit bias, health literacy, cultural agility, and the social determinants of health. Training encompasses the *Closing the Gap* cultural competency curriculum created by the Cross Cultural Health Care Program (*www.xculture.org*), as well as the *Bridges Out of Poverty* program (*www.ahaprocess.com*), which identifies practical ways to build trusting relationships with disadvantaged populations and to reduce barriers to accessing care. Advantage intends to share its results with CCOs and community advisory councils in order to improve and advance culturally competent dental care in our state.

communities based on a model pioneered in Alaska. Objectives include increasing the number of Native providers, expanding access, increasing patient education, increasing treatment of decay, lowering decay rates, and improving oral self-care. DHAT trainees are nominated by tribal education officers, in close collaboration with educational and career counselors, tribal health and dental directors, tribal leaders, and the students' families. Students are then sent to Alaska for two years of training.

- **Training dental hygienists to place interim therapeutic restorations**. This project tests the ability of EPDHs to place interim therapeutic restorations (ITRs). OHSU and Capitol Dental are currently sponsoring a demonstration project.

OHA pilot rules specify that outcome and cost data must be reviewed by third-party evaluators. As of summer 2016, OrOHC is facilitating a multi-stakeholder dental pilot taskforce to expand both the DHAT model and an EPDH advanced standing dental therapist model to serve low-income, rural and minority communities. Both models would include Commission on Dental Accreditation-approved training through hygiene schools. This initiative is still in the development phase and would require additional funding.

Cultural Competence and Diversity

Achieving optimal oral health for Oregon requires recruiting and training a culturally and linguistically diverse dental workforce with expertise in treating underserved populations. Despite the importance of this topic in our increasingly diverse state, we found relatively few concrete examples of improved cultural competence in the oral health professions.

Cultural competence is not just a matter of improving personal interactions; it also has a clinical component. Individuals from different racial, ethnic and cultural groups may have different values relating to oral health and different perceptions of pain, and providers must understand these differences in order to engage patients and make accurate diagnoses. Further, certain medications (including pain medications) may vary in their effects on patients of different races and ethnicities.

Although the Oregon Board of Dentistry asks renewing licensees to self-report on cultural competence continuing education (CCCE), training statistics are not available as of 2016. Beginning in 2017, health regulatory boards will submit these data to OHA. In coming years, OHA's health care workforce survey will also include a question about CCCE. In addition, OHSU has introduced cultural competency training as a requirement for all third-year dental students. Roughly 75 students receive this training each year.

OHSU reports that in the 2015-16 academic year, a little more than 26 percent of the students admitted to dental programs belonged to an underrepresented minority group: 20 percent were Asian, 5 percent were Hispanic/Latino and 1 percent were African-American.

According to 2012 data, Oregon's dentist workforce consisted primarily of white, male general dentists who work in private practice. Although Oregon's population is growing more diverse, the makeup of our dentist workforce has changed little since 2012 (with the exception that the number of general dentists has declined by nearly 5 percent).

On a more positive note, dentists are Oregon's most language-diverse health care workforce. Currently, 35 percent of dentists speak at least one language other than English. Between 2010 and 2014, the language diversity of Oregon's dental workforce increased by a range of 7 to 10 percent.

Traditional health workers (THWs)

In 2015, the passage of HB 2024 directed OHA to adopt rules and procedures for training and certifying THWs to provide culturally appropriate oral disease education, outreach and navigation services.

Some stakeholders believe that the THW role needs refinement and better definition, particularly in legislation. The oral health content of THW training is still under development, and some THWs do not yet see the value of undergoing this mandated oral health education.

Health Share CCO is now developing THW payment models. Kaiser Permanente is also a strong supporter of the THW model and was involved in the legislation that mandated oral health education for THWs.

In a related project, Providence Health & Services is working in Multnomah, Washington and Yamhill counties to provide oral health training to 200 volunteers in the Promotoras program. (Promotoras are Latino community members who are trained as community health workers to provide culturally appropriate outreach, education, navigation and translation services to disadvantaged and underserved populations, including migrant and seasonal farm workers.)

The Oregon Dental Association (ODA) is interested in advancing the American Dental Association's community dental health coordinator (CDHC) model, which has been implemented in 26 communities and eight states. In addition to providing oral health promotion and preventive services, CDHCs help at-risk populations access dental care. ODA is now working with local dental assisting and hygiene education programs to explore developing a CDHC training program.

Community-Based Rotations

The *Strategic Plan* recommended increasing dental student rotations in rural and underserved areas. As of 2015, OHSU dental students must complete a five-week community site rotation — an increase from two-week rotations. In the 2015-16 academic year, 37 students spent at least 20 days in rural areas and an additional five days working with underserved patients at Russell Street Clinic in Portland. These rotations annually provide more than $1 million in services for underserved Oregonians.

As of August 2016, the National Health Service Corps (NHSC) *Students to Service* loan repayment program is open to medical and dental students who plan to pursue a career in primary care and are committed to working in underserved communities. Participants will receive up to $120,000 tax-free for at least three years of full-time service at an NHSC-approved site in a health professional shortage area of greatest need.

Additional funding is needed to incentivize dental providers to work in rural and medically underserved areas, as is wider availability of student loan repayment programs. Currently, the Office of Rural Health, the Oregon Primary Care Association, OHA's Primary Care Office and others are promoting student loan repayment programs and related incentives. At the same time, the Oregon Health Policy Board and its workforce committee are recommending changes to provider incentive programs as required by HB 3396. This bill also established a Health Care Provider Incentives Fund, which will support an OHA-directed provider incentives program.

Teledentistry and Mobile Services

The *Strategic Plan* emphasized the need to equip providers with education and technology that facilitate care for underserved and geographically isolated patients. Teledentistry and mobile dental units were identified as important elements of this effort. As of 2016, teledentistry programs are being planned in several areas that have few or no dental providers, including Columbia,

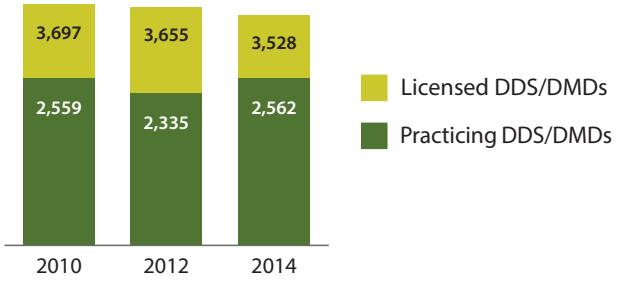
SPOTLIGHT ON SUCCESS

In 2009, Samaritan Lebanon Community Hospital saw a marked increase in the number of adult patients visiting the emergency department for nontraumatic dental problems. The CEO convened community members and staff to discuss this problem, which resulted in the formation of the Linn County Oral Health Coalition. Working closely with the well-established Benton County Oral Health Coalition, they developed a plan to meet the dental needs of uninsured and underinsured adults by coordinating dental vans with a voucher program. Subsequently, the Coast to Cascades Community Wellness Network — comprising Samaritan executives, health plans, health departments, nonprofits, education institutions and health care practitioners in Benton, Lincoln and Linn counties — identified oral health as a regional priority, which led to the formation of the Benton, Lincoln, Linn Regional Oral Health Coalition of Oregon. After studying oral health delivery models from across the nation, the Coalition launched the *Healthy Smiles for All* initiative, which has three key strategies:

- Identify areas with a substantial number of uninsured adults who have dental needs, and partner with Medical Teams International to deliver treatment through mobile dental units. Since 2014, this strategy has provided $115,454 in oral health services to 314 patients in East Linn and Lincoln counties.
- Make dental vouchers available to uninsured adults who are screened and referred through a partnership between The River Center in Lebanon and local private-practice dentists. To date, 141 patients have received $62,625 in services.
- Co-locate EPDHs in clinics through a partnership of Samaritan Health Services and Capitol Dental Care, Inc. This program started in Sweet Home, where an EPDH provides screenings, x-rays and preventive services five days a week. A dental van is also available one day a week to address emergency needs. This program has since been expanded to clinics in Lebanon and Brownsville. To date, it has provided 829 patients with more than $113,829 in services. It will serve Lincoln County residents beginning in 2017.

Healthy Smiles for All received three-year grant funding from the U.S. Health Resources and Services Administration. The grant is supported and monitored by the Coast to Cascades Community Wellness Network.

Dentists Licensed in Oregon, 2010 to 2014



Dental Hygienists Licensed in Oregon, 2010 to 2014

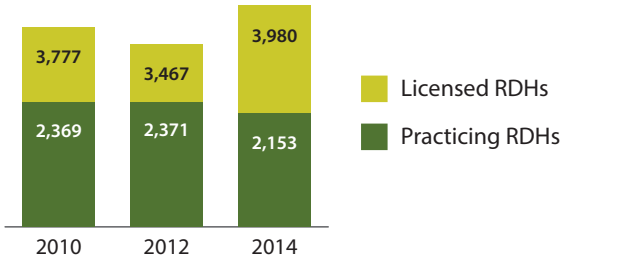


Chart adapted from *Oregon Health Professions: Occupational and County Profiles.* Oregon Health Authority, Oregon Healthcare Workforce Institute, and the Oregon Center for Nursing, August 2015. Used by permission.

Lincoln, Sherman and Gilliam counties. Some programs are awaiting grant funding from HRSA. Others are now underway:

- Capitol Dental is collaborating with OHSU and Dr. Paul Glassman to test teledentistry at five schools in Polk County through a grant from the Office of Rural Health. (This is a component of the ITR pilot described on page 15.)
- A co-located Capitol Dental hygienist is providing teledentistry services at the Children's Health Associates practice in Salem. In fall 2016, Capitol Dental will work with Yamhill CCO to provide teledentistry services with a focus on children with special needs (see page 11).

Mobile dental services continue to be invaluable in reaching underserved and geographically isolated patients:

- The Tooth Taxi has served more than 18,000 children at more than 346 sites since 2008. The estimated value of these donated services exceeds $5.5 million. The Tooth Taxi is a program of the Dental Foundation of Oregon, which was created through a partnership of Moda Health, OEA Choice Trust and the Oregon Dental Association.
- Medical Teams International (MTI) operates three vans in the tri-county Portland region, one in the mid-valley region, one in Central Oregon, and one in Roseburg. Most patients are adults. In Central Oregon, MTI works with Mosaic Medical FQHC to provide care to underserved clients. In the Portland area, Providence sponsors monthly MTI clinics to provide follow-up care for uninsured patients who visited a Providence emergency room for nontraumatic dental problems. MTI is also interested in repurposing vans to provide integrated medical and dental services.
- The Oregon Dental Association organizes Mission of Mercy, an annual two-day event at which volunteer dentists, hygienists and assistants provide cleanings, diagnosis and restorative services. Since 2010, almost 8,000 patients in Portland, Salem and Medford have received approximately $4.7 million in care.

Expanded Practice Dental Hygienists (EPDHs)

The *Strategic Plan* recommended more effective deployment of EPDHs to treat underserved and geographically isolated populations, including OHP patients. It also recommended that EPDHs work at the top of their licensure so that dentists don't need to spend time on care that could safely be delivered by a hygienist or other provider.

The number of licensed EPDHs in Oregon has nearly tripled in the past several years, rising from roughly 200 in 2013 to 633 in 2016. Currently, 122 EPDHs are enrolled as OHP providers. DCOs are increasingly investing in EPDHs with restorative capabilities. According to a 2015 study in the *Journal of Dental Hygiene*, most EPDHs in Oregon have a strong focus on pediatric patients and practice in school settings or residential care facilities.

Current EPDH utilization should be assessed statewide to identify opportunities to expand their use in underserved areas. As an example, AllCare CCO is considering placing an EPDH at South Coast Community Health in Port Orford, which has no dentist.

OHA has changed the dental periodicity assessment schedule to enable EPDHs to perform oral health assessments in alternative care settings such as Head Start sites. This has increased their flexibility and capacity for providing preventive services outside the dental office. However, many EPDHs still face obstacles to working at the top of their license, and some also report difficulties earning a living wage or getting reimbursed through fee-for-service payments.

Priority Area 3: Outcome Measures	Total	Source
Expanded practice dental hygienists (EPDHs) practicing in Oregon communities	—	ODHA
Dental students completing a 30-day rural rotation	—	OHSU
Proportion of underrepresented minority students admitted to dental programs	26.3%[1]	OHSU
Oral health care providers who completed cultural competency training	—	OHA

1. Oregon Health & Science University data for 2015-16 academic year. Comparable data for dental hygiene students are unavailable at the time of printing.

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Optimal oral health is fundamental to our well-being, happiness, productivity and quality of life.

OREGON ORAL HEALTH COALITION

The Oregon Oral Health Coalition (OrOHC) was formed in 2006 by the State Oral Health Program and health professionals concerned about oral health in Oregon.

As a nonprofit with diverse stakeholders, OrOHC provides support and leadership to professional and advocacy groups, local and state government agencies, and other organizations working to achieve optimal oral health for all Oregonians. Our aim is to organize stakeholders' individual strengths into a collective force for oral health.

OrOHC's mission is to serve as the central source for advocacy, information and communication about oral health issues in Oregon.

www.orohc.org

Oregon Health Authority

Oregon Health Authority (OHA) is at the forefront of lowering and containing costs, improving quality, and increasing access to health care in order to improve the lifelong health of Oregonians.

OHA is working to fundamentally improve how health care is delivered and paid for. Because poor health is only partially due to lack of medical care, OHA also works to reduce health disparities and to broaden the state's focus on prevention.

OHA's mission is to help people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.

www.oregon.gov/oha/

Oral Health Funders Collaborative
of Oregon and SW Washington

The Oral Health Funders Collaborative of Oregon and Southwest Washington is a partnership consisting of 13 regional grantmakers who are coordinating their efforts to identify, advocate and invest in lasting oral health solutions for Oregon and southwest Washington.

Members: *Cambia Health Foundation, CareOregon Dental, The Ford Family Foundation, Grantmakers of Oregon and Southwest Washington, Kaiser Permanente, Meyer Memorial Trust, Moda Health, Northwest Health Foundation, The Oregon Community Foundation, Oregon Dental Association, Providence Health & Services, Samaritan Health Services, and Washington Dental Service Foundation.*

www.oregoncf.org/ocf-initiatives/ohfc

The Strategic Plan for Oral Health in Oregon highlights strategies that will deliver **better care, better health and lower costs** for Oregonians of all ages and backgrounds.

To get involved,

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OREGON ORAL HEALTH COALITION

Oregon Health Authority

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