The Alaska Oral Health Program, Department of Health and Social Services, applied and received funding under the U.S. Health Resources and Services Administration, Maternal Child Health Bureau for four years (activities in FFY2004-FFY2007) under the State Oral Health Collaborative Systems (SOHCS) grant. The Alaska program has used this funding, leveraging state infrastructure funding from the U.S. Centers for Disease Control and Prevention, for three specific program activities: child dental assessments (surveillance); implementation of a dental education/prevention curriculum in Head Start grantee programs; and hiring of a statewide sealant coordinator to work collaboratively with tribal, community health center and private dental programs to increase availability to dental sealants in schools with high percentages of children from low-income families.

Goals, objectives and action steps listed in the grant application were largely accomplished. The program contracted for dental assessments in 2004 (3rd grade); 2005 (kindergarten and Head Start); and 2007 (updates on kindergarten and 3rd grade). The part-time dental sealant coordinator worked with the program to conduct an inventory of existing sealant programs (tribal programs), identify target schools and develop priorities for implementation for programs. The program conducted a “Cavity Free Kids” training for Head Start grantees in 2005 and is doing refresher trainings in 2007 and beyond – an Interior (Fairbanks) region training was held in October 2007. Future trainings will be done on a regional basis in conjunction with Head Start meetings.

**Dental Assessments (Surveillance):**

In 2004, the Oral Health Program contracted for conducting a dental assessment of Alaskan 3rd grade children. Visual dental assessments were conducted using the Association of State & Territorial Dental Director (ASTDD) Basic Screening Survey method in 50 elementary schools to provide state and regional (5 regions used in the department’s Behavioral Risk Factor Surveillance Survey) baselines on caries experience (past or present dental decay), untreated caries and dental sealant utilization (at least one dental sealant on at least one permanent first molar). The assessments also collected information with the parental consent form on dental access, Medicaid enrollment and other sources of dental coverage. Tribal dental programs assisted with the dental assessments in rural/remote regions of the state to reduce transportation costs associated with the data collection.

The 3rd grade dental assessment found high rates of caries and untreated caries in Native Alaskans as had been highlighted in the 1991 and 1999 Indian Health Service dental assessments. The survey also found high rates of decay in Asian and Native Hawaiian/Pacific Islander children and lower levels of dental access for these non-Native racial/ethnic minorities as measured by their lower dental sealant utilization. Survey results speak to the need to expand sample size in more urban areas of the state to get more non-Native racial/ethnic minorities in the sample (lower sample size in these groups led to wider confidence intervals). Also, see Figures 1-2 for the results on caries experience and untreated caries.

The 3rd grade assessment also found an overall dental utilization of 52.4% - making Alaska one of five states that have met the Healthy People 2010 goal of 50% for dental sealant utilization for children in this general age range. The survey found Alaska Native 3rd graders, an at-risk group for development of decay, had even a higher sealant
Alaska Oral Health Program – HRSA SOHCS Grant Activities
Grant Number H47MC02094
utilization rate (67.8%). The survey showed the need to improve sealant utilization in
non-Native racial ethnic minorities (See Figure 3) and white children enrolled in
Medicaid/Denali KidCare (See Figure 4).

This data was used in the 5-year needs assessment for the Alaska Maternal Child Health
Block Grant, for reporting on the dental sealant MCH performance measure,
development of the MCH Fact Sheet on children and adolescent oral health in Alaska
(See Attachment #1) and presentations on the mid-course review for Healthy Alaskans 2010. It is also being used in development of the state oral health plan and oral disease
burden document. Summary results for the dental assessments with confidence intervals
can be found in Attachment #2.

In 2005, dental assessments were done on Alaskan kindergarten children and children
enrolled in Head Start to establish baselines on these younger age groups of children (as
well as collect data on early childhood caries). This information will be used to evaluate
collaborative program activities with education and preventive dental services (e.g.,
topical fluorides) for pre-school aged children in Alaska. Kindergarten assessments also
included height weight data for calculations of Body Mass Index (BMI) for the Obesity
Prevention Program. Results from the 2005 dental assessments have been used for MCH
Block Grant reports, presentations to Head Start Programs and are being integrated in the
state oral health plan and oral disease burden document.

Figure 1 – Caries Experience (Past or Present Dental Decay) in Alaskan 3rd Graders (2004)
Racial/Ethnic Groups

---

SOHCS Overview: 2004-2007
Figure 2 – Untreated Caries (Dental Decay) in Alaskan 3rd Graders (2004)
Racial/Ethnic Groups

Third Graders -- Untreated Caries
Percent with Untreated Caries by Race/Ethnicity

![Graph showing untreated caries by race/ethnicity.]

Figure 3 – Dental Sealant Utilization in Alaskan 3rd Graders (2004)
Racial/Ethnic Groups

Third Graders -- Dental Sealants
Percent with Dental Sealants by Race/Ethnicity

![Graph showing dental sealant utilization by race/ethnicity.]

SOHCS Overview: 2004-2007
The 2005 dental assessment on kindergarten children found an overall caries experience rate of 48.2% with higher rates in Alaska Native kindergarten children (75.7%) and other racial ethnic groups (60.2%) – See Figure 5. Untreated caries reflected a similar pattern with 24.6% of all children with untreated decay and higher rates in Alaska Native kindergarteners (37.1%) and other racial/ethnic groups (29.6%) – See Figure 6. Early childhood caries as indicated by caries in primary anterior teeth was evident in 14.2% of all kindergarteners without twice that rate (28.1%) for Alaska Native kindergarteners – See Figure 7.

The 2005 dental assessment of children enrolled in Head Start found an overall caries experience rate of 68.8% - See Figure 8. Children enrolled in Head Start are at at-risk group for high caries rates due to lower socioeconomic status and also higher percentages of children from racial/ethnic minorities than in the general population. Caries experience was 84.2% for Alaska Native children enrolled in Head Start. Untreated caries for children enrolled in Head Start was 40.5% with a higher percentage for Alaska Native children (50.8%) – See Figure 9. Early childhood caries as indicated by caries in primary anterior teeth was evident in 42.5% of all children enrolled in Head Start and 60.9% for Alaska Native children enrolled in Head Start – See Figure 10.

The data collected on kindergarten and Head Start children has been used in presentations on oral disease in Alaska, the Healthy Alaskans 2010 mid-course review presentation for oral health and is planned for use in the state oral health plan and oral disease burden document. The information has also been used for presentations to Head Start grantees including the “Cavity Free Kids” training discussed below.
Figure 5 – Caries Experience from the Kindergarten Dental Assessment (2005)

Percent of Kindergarteners with Caries Experience by Race

Total Alaska Native White Other

- Total with Caries Experience
- Healthy People 2010 Goal

Figure 6 – Untreated Caries from the Kindergarten Dental Assessment (2005)

Percent of Kindergarteners with Untreated Caries by Race

Total Alaska Native White Other

- Total with Untreated Caries
- Healthy People 2010 Goal
Figure 7 – Caries on Primary Anterior Teeth from the Kindergarten Dental Assessment (2005)

Percent of Kindergarteners with Caries Experience on Primary Anterior Teeth by Race

- Total: 14.2%
- Alaska Native: 28.1%
- White: 10.2%
- Other: 17.3%

Figure 8 – Caries Experience from the Head Start Dental Assessment (2005)

Percent of Head Start Children with Caries Experience by Race

- Total: 68.8%
- American Indian/Alaska Native: 84.2%
- White: 48.1%
- Other: 45.7%

SOHCS Overview: 2004-2007
Figure 9 – Untreated Caries from the Head Start Dental Assessment (2005)

Percent of Head Start Children with Untreated Caries by Race

<table>
<thead>
<tr>
<th>Race</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>40.5</td>
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<tr>
<td>American Indian/Alaska Native</td>
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<td>White</td>
<td>24.1</td>
</tr>
<tr>
<td>Other</td>
<td>27.7</td>
</tr>
</tbody>
</table>

Figure 10 – Caries on Primary Anterior Teeth from the Head Start Dental Assessment (2005)

Percent of Head Start Children with Caries Experience on Primary Anterior Teeth by Race

<table>
<thead>
<tr>
<th>Race</th>
<th>Percent</th>
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</thead>
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<tr>
<td>American Indian/Alaska Native</td>
<td>60.9</td>
</tr>
<tr>
<td>White</td>
<td>18.5</td>
</tr>
<tr>
<td>Other</td>
<td>19.1</td>
</tr>
</tbody>
</table>
Updates to the dental assessments for kindergarten and third-graders (statewide results) have been conducted and the report on this project should be available by January 2008. It is hoped a dental assessment update can be conducted in 2010/2011 as part of the Healthy People state process and the next MCH needs assessment, however funding has not been identified at this time. It is hoped that by leveraging the MCH needs assessment process, collecting information on height and weight and collaboration with tribal programs will assess with the next dental assessment project.

Dental Education & Prevention for Head Start Grantee Programs (Cavity Free Kids):
In 2005 SOHCS grant funds also supported a train-the-trainer workshop for implementation of the “Cavity Free Kids (CFK)” oral health curriculum in Head Start grantee programs. CFK curriculum was developed by the Washington State Dental Services Foundation and was used in Washington State, Hawaii and California at the time of the Alaska training. The CFK program trains Head Start teachers and staff to integrate oral health education and preventive activities in the classroom through use of the curriculum and suggested activities. The CFK program in Alaska also offers an opportunity to develop fluoride varnish programs in the Head Start setting by integrating the curriculum with tribal dental program preventive activities.

The train-the-trainer workshop had 47 participants from across the state. Travel costs associated with the training were supported by the State Head Start Collaboration Office with SOHCS grant funding paying for the trainers and training notebooks.

The Oral Health Program collected information on the progress on implementation of the CFK curriculum in Head Start Programs in the winter of 2006 (See Attachment #3). Head Start Grantee program shared experiences using the curriculum, tips on some of the demonstrations and expressed the need for a follow-up refresher for to re-stimulate use of the curriculum with new teachers. The Oral Health Program is working with the Head Start Collaboration Office to provide regional trainings during other Head Start meetings in 2007-2008. A training workshop was held in Fairbanks in October 2007 with 15 individuals from Region X and Region XI (tribal) Head Start Programs. The Oral Health Program provided an overview on oral diseases in Alaska and prepared notebooks for trainers and the Head Start Collaboration Office assisted with some travel funds for two individuals to attend the regional training.

The ongoing trainings on “Cavity Free Kids” also provide an opportunity to encourage increased utilization of topical fluoride varnish. Tribal programs currently have the capability to provide fluoride varnish application by medical providers as part of well child exams; with community health aides or dental health aides. Work with Early Head Start Programs could assist in increasing dental visits by age one.

Statewide Sealant Coordinator:
The SOHCS grant funded a part-time statewide dental sealant coordinator in late 2006 through August 2007. The grant also supported this position for a month in 2005 to coordinate the CFK training discussed above and to oversee a CDC-funded professional services contract to inventory access to school-based/linked dental sealant programs in elementary schools in Alaska. This position was also used to help organize the a “Children with Special Health Care Needs (CSHCN) Oral Health Forum” in February

SOHCS Overview: 2004-2007
Alaska Oral Health Program – HRSA SOHCS Grant Activities
Grant Number H47MC02094

2007 and plan for a follow-up meeting in November 2007. The forum developed a preliminary action plan (Attachment #4) – the follow-up meeting is to focus on development of a resource notebook for parents of CSHCN to be available through Stone Soup Group, Inc. (Family Voices organization for Alaska) and to prioritize recommendations for the action plan and integrate the recommendations into the state oral health plan.

The study found school-based/linked services provided by tribal dental programs in 149 of the 358 Alaska elementary schools. In some cases the services are provided by the tribal programs on-site in the schools (school-based) and other times in working with schools to coordinate dental visits in the village dental clinics (school-linked). In almost all of these cases the dental sealant activities are being done as a component of a comprehensive dental program, although several tribal programs augment dental sealant utilization through targeted school-based sealant activities.

The study found that schools with high percentages of children from low-income families without school-based/linked dental sealant programs were largely in regional hub communities (e.g., Dillingham and Nome) or more urban areas of the state (e.g., Anchorage, Fairbanks, Kenai, Ketchikan, Juneau and Sitka). Attachment #5 provides a summary of the results from the dental sealant program inventory for schools. Eligible schools are defined as rural schools in regions with median family income at or below 235% of federal poverty level and urban schools with 50+% of children enrolled in the free and reduced school lunch program. Sealant estimates in the summary are based on information from the 2004 dental assessment of third-grade children (Basic Screening Survey project).

The statewide sealant coordinator will be working to develop a collaborative approach leveraging tribal, community health center and private dental programs and Medicaid funding to establish school-based/linked dental sealant programs in collaboration with schools and their respective school districts. The priority will be for development of such programs in schools with high percentages of children from low-income families as measured by participation in the free and reduced school lunch program (urban areas) or median family income (rural and remote areas). Additionally, the sealant coordinator will assist the Oral Health Program in development of an evaluation plan and methods for these sealant programs. The person in this position will be shifted to funding under the recently awarded Targeted Oral Health Collaborative Systems Grant. Additional duties will include:

- assisting with case management to find dental services for CSHCN;
- develop capacity for age one dental referrals in an incremental approach – initially working with pediatric dentists, tribal and community health center dental programs;
- assisting the Dental Officer with reports to the state legislature in the process for reauthorization of adult dental Medicaid services (this includes preventive and enhanced dental restorative services for pregnant women.)
The SOHCS grant program has allowed Alaska to leverage resources to establish basic oral health infrastructure in the health department. The Alaska Oral Health Program was implemented only five years ago, July 2002, with core funding from the CDC Division of Oral Health. The program receives some funding from the Medicaid program for the Dental Officer’s assistance on Medicaid/SCHIP activities. The goal is to build program sustainability through increased collaboration with Head Start, the MCH program and continued grant funding. The SOHCS grant provided funding for dental assessments to develop the state oral health surveillance system, staff infrastructure (part-time dental sealant coordinator), and opportunities for increased collaboration with programs providing health and education services for children (e.g., CSHCN, Maternal Child Health Program and Head Start Programs).

**Attachments:**

Attachment #1 – Oral Health Fact Sheets for the MCH Program  
Attachment #2 – Summary of the 2004 and 2005 dental assessment projects  
Attachment #4 – Initial dental action plan from the “CSHCN Oral Health Forum”  
Attachment #5 – Summary from the dental sealant program inventory
Attachment #1

Oral Health Fact Sheets for the MCH Program
Child and Adolescent Oral Health in Alaska

Despite dramatic reductions in tooth decay over the past century, dental decay remains one of the most common childhood diseases in the United States. According to the Centers for Disease Control and Prevention, dental decay is the second most common chronic disease among U.S. children.\(^1\) Dental decay is 5 times more common than asthma and 7 times more common than hay fever.\(^2\) In the United States, 25% of children and adolescents experience 80% of all dental decay occurring in permanent teeth.\(^3\) Fluoridated water, toothpastes, supplements and topical rinses/gels along with dental sealants have decreased the extent of decay in children. However, children in low-income families are disproportionately affected by dental decay.

**Seriousness**

*Healthy People 2010 Targets and National Data*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Alaska 2004</th>
<th>Nation 2000</th>
<th>Healthy People 2010 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of 3rd graders with at least one sealant on a permanent molar tooth</td>
<td>52.4%</td>
<td>28%(^1)</td>
<td>50%</td>
</tr>
<tr>
<td>Proportion of 3rd graders that have experienced tooth decay</td>
<td>65.1%</td>
<td>50%(^2)</td>
<td>42%</td>
</tr>
<tr>
<td>Proportion of 3rd graders with untreated decay</td>
<td>28.0%</td>
<td>24%(^3)</td>
<td>21%</td>
</tr>
</tbody>
</table>

1. National data is for children ages 6-8 years only
2. National data is for children ages 8 years only

- Alaska has achieved the Healthy People 2010 (HP2010) goal for sealant utilization among 3rd graders; furthermore, the proportion of Alaskan 3rd graders with at least one sealant on a permanent tooth was nearly 2 times higher than that of eight year olds in the Nation as a whole.

- The proportion of Alaskan 3rd graders that have experienced dental caries is more than 1.5 times higher than the HP2010 goal and 1.3 times higher compared to children ages 6-8 years nationally.

- Untreated dental decay among Alaskan 3rd graders is slightly higher than both the HP2010 goal and the proportion of 6-8 year olds with untreated dental decay in the Nation as a whole.

**Severity**

Dental decay is a preventable health problem; however, left untreated it can significantly affect health, ability to concentrate in school, and quality of life.\(^1\) Nationally, children miss almost 52 million school hours annually because of oral health problems.\(^4\) Extensive tooth decay, pain, or infection can cause eating, learning, and speech problems for children. Furthermore, many adolescents with oral problems such as decayed or missing teeth suffer embarrassment and diminished self-esteem.

**Urgency**

- An oral health screening of Alaska Native dental clinic users during 1999 indicated Alaska Native children experienced 3 to 4 times the amount of dental decay as their national counterparts.\(^5\)

- Additionally, severe early childhood caries was found in 59.7% of 2-4 year old Alaska Native children screened during the project.\(^6\)

- Medicaid/Denali KidCare is the dental coverage source for many of the children and adolescents with special health care needs. Only about 1 in 3 children enrolled in Medicaid/Denali KidCare receive an annual dental service.\(^7\) Furthermore, many dentists are not accepting new Medicaid clients in their practices and the state has only 14 pediatric dental specialists.

Compounding the problem, the Alaska dental labor force is aging: during Fiscal Year 2002 more than 25% of active, licensed dentists were age 55 years and older and 39% were age 45-54 years.\(^7\)

**Disparities**

Children in families with low incomes have 5 times more untreated decay than children in higher income families.\(^8\) Data from the 2001 National Health Interview Survey found that problems related to oral health are more common among black, Hispanic, and low-income children in the United States.\(^9\)

- Nearly 80% of children living at or above the Federal Poverty Level (FPL) had seen a dentist in the past year of the survey, compared to 62% of children below 200% of the FPL.\(^1\)

Data from the 2004 Oral Health Assessment of Alaskan 3rd graders indicated that race was significantly associated with oral health issues. Among 3rd grade children in the

For further information on this topic, please contact the State of Alaska, Department of Health and Social Services Women's, Children's, & Family Health Section at 907-334-2424 or visit our web site at www.epl.hss.state.ak.us/mchepi
State, Alaska Natives were significantly more likely to have experienced dental caries and to have untreated dental caries than white children.

- The prevalence of Alaska Native 3rd graders with a history of dental caries was 1.6 times higher than that of either white or black children – 87.3%, 54.7% and 53.7%, respectively.1
- Among Alaskan 3rd graders, Alaska Native children were 2.3 times more likely to have untreated dental caries compared to white children – 43.5% and 18.6%, respectively.7
- A history of dental sealants was more common among Alaska Native children (67.8%) than white (51.0%), black (29.6%), or Asian/Pacific Islander children (33.3%).5

**Economic Loss**
Nationally, an estimated 5-10% of preschool-age children have baby bottle tooth decay (early childhood caries).7 The cost of treating early childhood caries is $1,000 – $2,000 per child and if hospitalization is required that cost is doubled.10 Further, children with early childhood caries may be highly susceptible to future caries development.11

**Interventions & Recommendations**
- The primary public health measures for reducing caries risk, from a nutrition perspective, are the consumption of a balanced diet and adherence to dietary guidelines and the dietary reference intakes; from a dental perspective, the primary public health measures are the use of topical fluorides and consumption of fluoridated water.14
- Support efforts to optimally fluoridate community water systems or increase use of fluoride supplements in areas where fluoridated water is not available. Currently, the Alaska Oral Health Program along with staff from the Alaska Native Tribal Health Consortium and regional tribal dental programs are promoting water fluoridation where it can be done in a safe and cost-effective manner.
- Increase education and support efforts to increase utilization of dental sealants.
- Increase and promote efforts to reduce the frequency and overall consumption of soda, juice, sugared drinks and diets high in sugar – and to increase water consumption as a healthy alternative to sugared drinks. This should include limiting access to high sugar drinks and foods in public schools.
- Support efforts to increase dental access in the Medicaid/Denali KidCare program.
- Support education and intervention efforts to screen infants for dental decay and early referral for infants with early signs of early childhood caries (e.g., change Medicaid guidance for a dental referral from age 3 to age 1).
- Support education and training opportunities to increase the number of pediatric dentists in Alaska and/or education of general dentists in treating young children. During the fall of 2005 the Alaska Native Medical Center will start a hospital-based pediatric residency program – this program offers hope to increase the number of pediatric specialists practicing in Alaska.
- Continue to monitor trends in oral disease, especially caries activity, among Alaskan children. During 2005, the Alaska Oral Health Program will be conducting an oral health assessment of kindergarten age children and children enrolled in Head Start.

**Intervention Effectiveness**
Fluoridation is the most efficient way to prevent dental caries in all children, regardless of socioeconomic status, race, or ethnicity. Water fluoridation can reduce cavities by up to 40%. Providing fluoridated water costs about 50 cents per person per year – much less than the cost of a single filling.12

Dental sealants (thin plastic coatings) protect the pits and fissures of teeth from decay. Dental sealants typically cost less than half of the average cost of a one-surface filling.13

**Capacity**

**Promiscuity**
Oral health among children and adolescents is an important issue among the Maternal and Child Health (MCH) population. Several national objectives have been set forth to address access, disparities, and general oral health (HP 2010) and the Maternal and Child Health Bureau requires sealant utilization among 3rd graders be monitored and assessed on a yearly basis (NPM #9).

**Economic Feasibility**
Economic feasibility was not evaluated.

**Acceptability**
Although acceptability was not evaluated, given the impact on the quality of life and health, it is an issue that would most likely be accepted among the target population.

**Resources**
Data sources: Alaska Oral Health Program; Medicaid.

**Legality**
Not an issue.

**References**
Data Sources


Oral Health Among Children with Special Health Care Needs in Alaska

Nationally, 12.8% of U.S. children and adolescents ages 0-17 years have special health care needs.\(^1\) The oral health of these children may be affected negatively by the medications (medications decreasing saliva flow), therapies, or special diets they require, or by their difficulty with cleaning teeth thoroughly on a daily basis.\(^2\)

Conditions that may lead to special health care needs include Down syndrome, cleft lip/palate and other craniofacial defects, cerebral palsy, learning and developmental disabilities, emotional disturbances, vision and hearing impairments, diabetes, asthma, genetic and hereditary disorders with orofacial defects, or HIV infection.

**Seriousness**

*Healthy People 2010 Targets and National Data*

A Healthy People 2010 Objective for oral health among children with special needs is to increase the number of states that have a system of recording and referring infants and children with cleft lips, cleft palates, and other craniofacial anomalies – Alaska currently has this system in place.

**Severity**

Children with disabilities present unique problems are at increased risk for oral infections, delays in tooth eruption, periodontal disease, enamel irregularities, and moderate-to-severe malocclusion (poor bite).\(^3\) Children with cleft lip/palate are at increased risk for dental caries, gingivitis, cross bite, and dental crowding.\(^4\)

**Urgency**

Alaska specific data on the prevalence dental needs for children and adolescents with special health care needs is limited. However, national data from oral assessments of U.S. Special Olympics athletes in 1999 (all ages), based on an extremely conservative protocol (visual assessment without use of mouth mirrors, dental explorers or x-rays), found 12.9% of the athletes reported some form of oral pain, 39% demonstrated signs of gingival infection, and nearly 25% had untreated dental decay.\(^5\)

Results of the 2001 National Survey of Children with Special Health Care Needs (CSHCN), 10.7% of children ages 0-17 in Alaska had special health care needs.\(^6\)

- Of Alaskan CSHCN in 2001, nearly 80% needed dental care, including check-ups in the past 12 months of the survey. Of these, 11.5% did not receive the dental care they needed.\(^7\)
- For the 5-year period 1998-2002, the rate of oral cleft among Alaskan children was 3.1 per 1,000 population\(^8\) – slightly higher than the national rate of 1.2 per 1,000 population.\(^9\)

- Medicaid/Denali KidCare is the dental coverage source for many of the children and adolescents with special health care needs. Only about 1 in 3 children enrolled in Medicaid/Denali KidCare receive an annual dental service.\(^10\) Furthermore, many dentists are not accepting new Medicaid clients in their practices and the state has only 14 pediatric dental specialists.

**Disparities**

- From 1998-2002, the 5-year rate of oral cleft was nearly 2 times as high among Alaska Native children as white children – 5.0 and 2.7 per 1,000 population, respectively.\(^9\)

**Economic Loss**

Economic loss was not evaluated.

**Interventions & Recommendations**

- Assess the number of children and adolescents with special health care needs in Alaska, their oral health needs, and issues affecting dental access.
- Assist training for pediatric dentists and/or general practitioners in patient management for children and adolescents with special health care needs. The aim should be to either reduce the number of times children need to undergo general anesthesia for dental care through providing services in outpatient settings or coordinating their dental treatment with other medical procedures when hospital-based care is needed.
- Because parents often lack confidence about performing oral hygiene care for their child because they do not have enough information about their child’s dental growth and development,\(^11\) training opportunities should be provided for parents and caregivers to educate on dental conditions, management of such conditions and provision of daily dental home care (brushing and flossing).

For further information on this topic, please contact the State of Alaska, Department of Health and Social Services Women’s, Children’s, & Family Health Section at 907-334-2424 or visit our web site at: www.epi.hss.state.ak.us/mchepi
• Support education efforts for use of folic acid prior to and during pregnancy to reduce neural clefts (including cleft lip and/or cleft palate).

• Dental care for children and adolescents with more severe disabilities is often done by dental pediatric specialists, however as children mature into adulthood the pediatric practices usually are not configured to accommodate adult patients, the disabled adult may find difficulty finding a general practitioner to provide dental care, and the individual may lose coverage for routine dental care (e.g., limited services for adults in many state Medicaid programs). The State should support efforts to increase dental access in the state’s Medicaid/Denali KidCare program along with efforts to provide some minimum level of routine dental care to adults with disabilities that are enrolled in Medicaid.

• The Alaska Native Medical Center will be starting a hospital-based pediatric residency program in the fall of 2005 – this program offers hope to increase the number of pediatric specialists practicing in Alaska.

Intervention Effectiveness
• The Alaska Maternal Child Health Block Grant coordinates services for treatment of cleft lip and/or cleft palate through regional specialty clinics. In state fiscal year 2004, 123 children received corrective services through these specialty clinics.9

Capacity

Prompety
Children with special health care needs have unique issues among the maternal and child health population. Promoting access to care, and monitoring and assessing the oral health needs of the CSICN population is within the overall mission of the Women’s, Children’s and Family Health Section.

Economic Feasibility
Economic feasibility was not evaluated.

Accountability
Although accountability was not evaluated, given the impact on the quality of life and health, it is an issue that would most likely be accepted among the target population and community.

Resources
State Oral Health Program; Specialty Clinics program;
Alaska Birth Defects Registry; National Survey of
Children with Special Health Care Needs.

Legality
Physicians, hospitals, and other health care facilities and providers must report children from birth up to one year of age who have any of the reportable birth defects under the Alaska Administration Code (7 AAC 27.012).

References

Notes
The U.S. Maternal and Child Health Bureau has defined children and adolescents with special health care needs as those "who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who require health and related services of a type or amount beyond that required by children generally."10
Oral Health Care among Pregnant Women and Women in Alaska

Oral diseases are among the most prevalent and preventable chronic health conditions in the U.S. — impacting the oral, general, and reproductive health of women, their quality of life, and the oral health of their children.  

Women’s oral health has improved during the last half century, yet oral diseases among women remain highly prevalent. According to the National Health and Nutrition Examination Survey (NHANES III) nearly 47% of the tooth surfaces among females ages 18 and older showed signs of tooth decay and approximately 67% exhibited clinical signs of gum disease.  

The hormonal changes that occur during puberty and pregnancy are associated with an increased incidence of gingivitis. Behavioral risk factors such as tobacco use and poor dietary practices may also influence oral health. Tobacco use is the most prevalent cause of oral cancer, and smoking may contribute to the early onset and severity of periodontitis. Eating disorders such as anorexia nervosa and bulimia nervosa are serious concerns in terms of women’s oral health and pose a clinical challenge to health professionals.  

**Seriousness**  
**Healthy People 2010 Targets and National Data**

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<thead>
<tr>
<th>Indicator</th>
<th>Alaska 2002</th>
<th>Nation 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of women ages 21-8 that had a dental visit for any reason within the past year</td>
<td>66.3%</td>
<td>71.5%</td>
</tr>
<tr>
<td>Proportion of women ages 21-8 that had teeth cleaned by a dentist or dental hygienist within the past year</td>
<td>63.1%</td>
<td>71.9%</td>
</tr>
<tr>
<td>Proportion of women ages 21-8 that have lost 6 or more teeth due to decay or gum disease</td>
<td>16.4%</td>
<td>18.6%</td>
</tr>
</tbody>
</table>

Alaska currently doesn’t have the capacity to assess Healthy People 2010 (HP2010) objectives surrounding oral health. Information on oral health and dental access among women of childbearing age in Alaska is not readily available. The 2002 Alaska Behavioral Risk Factor Surveillance Survey (BRFSS) has an oral health component, but it is limited in its comparability to the HP2010 objectives. The Alaska Pregnancy Risk Assessment Monitoring System (PRAMS) began collecting data on access to dental care among pregnant women with the 2004 survey. It will be available in the Fall of 2005.

- The percentage of Alaskan women, ages 18 and older, that reported having lost 6 or more teeth due to decay or gum disease was not significantly different from the Nation.

**Severity**

Over an individual’s life, oral diseases and conditions are progressive and cumulative; resulting in severe and debilitating conditions in the absence of appropriate treatment. The impact of oral disease may extend beyond a woman’s oral health to the health of her infant. Periodontal diseases among pregnant women may increase the risk preterm birth (under 37 weeks gestation), low birth weight (less than 2,500 grams), and low weight for gestational age.

Maternal oral health is an important factor in preventing early childhood caries in infants. Along with diet and feeding practices, rampant decay in the mother’s mouth is an increased risk factor for early development of dental decay in the infant as the primary teeth erupt. Streptococcus mutans, the bacteria primarily responsible for initiation of dental decay, is usually passed from mother or caregiver to child. Children diagnosed with early childhood caries may be highly susceptible to future caries (dental decay) development.

**Urgency**

- Nationally, about 70% of the women who participated in NHANES III reported having a dental visit during the previous 12 months; yet an analysis of four states participating in the Pregnancy Risk Assessment Monitoring System (PRAMS) indicated that only 23%-35% of women reported having a dental visit during their most recent pregnancy.
In 2002, more than 1 in 3 Alaskan women, ages 18 and older, reported they hadn’t had their teeth cleaned by a dentist or oral hygienist within the past year; and 1 in 3 reported they hadn’t had a dental visit for any reason within the past year.10

In 2002, 17.7% of Alaskan women smoked cigarettes during the last three months of pregnancy and 5.0% used smokeless tobacco.11

Disparities
A variety of demographic, general health, behavioral, economic, and social risk factors place some women at high risk for the development of oral diseases. Social and economic influences may impact women’s utilization of oral health services and, ultimately, their oral health status. Women who lack information about available resources, and who report being unable to obtain services due to poverty or lack of insurance, may have difficulty accessing services and optimizing their oral health.10,12

A study of oral health during pregnancy using data from four states participating in PRAMS found that, among women who perceived a need for oral health care during their pregnancy, those enrolled in Medicaid were 24%-53% less likely to seek oral health care than those with private insurance.13

Analysis of Alaska PRAMS data showed that race, education, region, and Medicaid status were significantly associated with prenatal tobacco use (cigarette smoking) and prenatal smokeless tobacco use.11 Refer to the fact sheet Prenatal Tobacco Use in Alaska for more detail about the disparities and interventions associated with prenatal cigarette smoking and prenatal smokeless tobacco use in Alaska.

Alaska Native mothers had the highest prevalence of prenatal tobacco use during the last three months of pregnancy (29.3%) – nearly 2 to 3 times that of white (14.9%) and Asian/Pacific Islander mothers (10.5%).11

Alaska Native mothers were 20 times more likely to report using smokeless tobacco while they were pregnant than white mothers – 17.8% and 0.9%, respectively.11

A screening of Alaska Native adults (males and females), ages 35-44 years, found:
- 50.8% had untreated dental decay at the time of the screening
- 51.3% reported tobacco use
- 37.4% had moderate to severe periodontitis.13

Similar information is not available solely for adult Alaskan women or for other racial or ethnic groups.

Economic Loss
Economic loss was not evaluated.

Interventions & Recommendations
- Continue education and other efforts to reduce tobacco use among adults with a directed approach to eliminate use of tobacco products during pregnancy. Refer to the fact sheet Prenatal Tobacco Use in Alaska for more information on this intervention and its effectiveness.
- Continue work on an oral health surveillance system to collect data on oral disease and dental access in Alaska (including information related to pregnant women and infants).
- Enhance the level of dental benefits to adults enrolled in Medicaid to include preventive and restorative dental services – or incrementally expand this service for pregnant women enrolled in Medicaid.
- Support efforts to reduce the level of oral disease (dental decay and periodontal disease) in pregnant women and mothers as means to improve birth outcomes, reduce the infant’s risk for development of early childhood caries, and improve women’s health.
- Support education and intervention efforts to screen infants for dental decay and early referral for infants with early signs of early childhood caries (e.g., change Medicaid guidance for a dental referral from age 3 to age 1).

Intervention Effectiveness
Intervention effectiveness for these recommendations was not evaluated.

Capacity
Proximity
Promoting oral health among the maternal and child health population in Alaska falls within the overall mission of the Women’s, Children’s, and Family Health Section. Poor oral health among Alaskan pregnant women and mothers can affect the health of their infants. There are several national objectives (HP2010) that address oral health and one is currently monitored on a yearly basis for the Title V MCH Block Grant.

Economic Feasibility
Economic feasibility was not evaluated.

Accountability
Although not supported with data, it is likely that promoting oral health would be acceptable among the target population, since quality of life issues and reduced general health are associated with poor oral health.
Resources

The department is working on a project to collect similar information on other racial/ethnic groups in the fall of 2005 through a federally funded contract doing dental assessments of kindergarten children and children enrolled in Head Start.

Alaska's Medicaid program only covers emergency dental services for immediate relief of pain and acute infection. Routine dental restorative and preventive services are not covered. This limits dental access and preventive dental care for dental decay and periodontal disease for all adults.

Legality

Not an issue.

References


Data Sources


Behavioral Risk Factor Analysis Surveillance System (BRFSS), 2002 Data: Centers for Disease Control and Prevention (CDC), Atlanta, Georgia: U.S. DHSS, CDC.

Notes

For Alaska PRAMS data note that prenatal tobacco use is cigarette smoking during the last three months of pregnancy for women that delivered a live-born infant. Prenatal smokeless tobacco is any use of smokeless tobacco during pregnancy for women that delivered a live-born infant.

Prevalence estimates for PRAMS data are among women that delivered a live-born infant.

National estimates for BRFSS are the median percent among all states that collected data on these topics in 2002.
Attachment #2

Summary of the 2004 and 2005 Dental Assessment Projects:

- 2004, Third Grade Basic Screening Survey
- 2005, Kindergarten Basic Screening Survey
- 2005, Head Start Basic Screening Survey
ALASKA – Oral Health Assessment, 2004 (3rd grade children)

Survey results listing the mean, confidence intervals and number of children in each category from the project for state totals, racial/ethnic groups and Medicaid enrolled children were as follows (2004/2005 school year – 3rd grade children):

<table>
<thead>
<tr>
<th>Caries Experience:</th>
<th>National (NHANES 1988-94)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (n=1,206)</td>
<td>65.1% (62.3, 67.8)</td>
</tr>
<tr>
<td>American Indian/Alaska Native (n=283)</td>
<td>87.3% (82.8, 90.9)</td>
</tr>
<tr>
<td>White (n=580)</td>
<td>54.7% (50.5, 58.7)</td>
</tr>
<tr>
<td>Asian (n=93)</td>
<td>84.9% (76.0, 91.5)</td>
</tr>
<tr>
<td>Black/African American (n=54)</td>
<td>53.7% (39.6, 67.4)</td>
</tr>
<tr>
<td>Hispanic/Latino (n=51)</td>
<td>51.0% (36.6, 65.2)</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander (n=21)</td>
<td>85.7% (63.7, 97.0)</td>
</tr>
<tr>
<td>Medicaid/Denali KidCare (n=336)</td>
<td>76.2% (71.3, 80.6)</td>
</tr>
<tr>
<td>American Indian/Alaska Native (n=128)</td>
<td>91.4% (85.1, 95.6)</td>
</tr>
<tr>
<td>White (n=99)</td>
<td>63.6% (53.4, 73.1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Untreated Caries:</th>
<th>National (NHANES 1988-94)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (n=1,205)</td>
<td>28.0% (25.3, 30.7)</td>
</tr>
<tr>
<td>American Indian/Alaska Native (n=283)</td>
<td>43.5% (37.6, 49.5)</td>
</tr>
<tr>
<td>White (n=580)</td>
<td>18.6% (15.6, 22.1)</td>
</tr>
<tr>
<td>Asian (n=93)</td>
<td>49.5% (38.9, 60.0)</td>
</tr>
<tr>
<td>Black/African American (n=54)</td>
<td>29.6% (18.0, 43.6)</td>
</tr>
<tr>
<td>Hispanic/Latino (n=50)</td>
<td>30.0% (17.9, 44.6)</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander (n=21)</td>
<td>52.4% (29.8, 74.3)</td>
</tr>
<tr>
<td>Medicaid/Denali KidCare (n=336)</td>
<td>34.2% (29.2, 39.6)</td>
</tr>
<tr>
<td>American Indian/Alaska Native (n=128)</td>
<td>50.8% (41.8, 59.7)</td>
</tr>
<tr>
<td>White (n=99)</td>
<td>15.2% (8.7, 23.8)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dental Sealants Present:</th>
<th>National (NHANES 1988-94)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (n=1,206)</td>
<td>52.4% (49.5, 55.3)</td>
</tr>
<tr>
<td>American Indian/Alaska Native (n=283)</td>
<td>67.8% (62.1, 73.3)</td>
</tr>
<tr>
<td>White (n=580)</td>
<td>51.0% (46.9, 55.2)</td>
</tr>
<tr>
<td>Asian (n=93)</td>
<td>39.8% (29.8, 50.5)</td>
</tr>
<tr>
<td>Black/African American (n=54)</td>
<td>29.6% (18.0, 43.6)</td>
</tr>
<tr>
<td>Hispanic/Latino (n=50)</td>
<td>42.0% (28.2, 56.8)</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander (n=21)</td>
<td>33.3% (14.6, 57.0)</td>
</tr>
<tr>
<td>Medicaid/Denali KidCare (n=336)</td>
<td>57.4% (52.0, 62.8)</td>
</tr>
<tr>
<td>American Indian/Alaska Native (n=128)</td>
<td>66.4% (57.5, 74.5)</td>
</tr>
<tr>
<td>White (n=99)</td>
<td>44.4% (45.2, 65.5)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Urgency – Early or Urgent Dental Care Needed:</th>
<th>National (NHANES 1999)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (n=1,206)</td>
<td>33.8 (31.2, 36.6)</td>
</tr>
<tr>
<td>American Indian/Alaska Native (n=283)</td>
<td>48.4 (42.5, 54.4)</td>
</tr>
<tr>
<td>White (n=580)</td>
<td>26.4 (22.9, 30.2)</td>
</tr>
<tr>
<td>Asian (n=93)</td>
<td>50.5 (40.0, 61.1)</td>
</tr>
<tr>
<td>Black/African American (n=54)</td>
<td>31.5 (19.5, 45.6)</td>
</tr>
<tr>
<td>Hispanic/Latino (n=50)</td>
<td>35.3 (22.4, 49.9)</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander (n=21)</td>
<td>57.1 (34.0, 78.2)</td>
</tr>
<tr>
<td>Medicaid/Denali KidCare (n=336)</td>
<td>41.7 (36.4, 47.2)</td>
</tr>
<tr>
<td>American Indian/Alaska Native (n = 128)</td>
<td>56.3 (47.2, 65.0)</td>
</tr>
<tr>
<td>White (n=99)</td>
<td>30.3 (21.5, 40.4)</td>
</tr>
</tbody>
</table>
Survey results reflect racial/ethnic variation in caries experience and untreated caries. The survey results also 
variation in caries based on socioeconomic status (with Medicaid eligibility indicating children from families with 
lower incomes). High caries rates in American Indian/Alaska Native (AI/AN) children has been noted previously in 
other surveys (e.g., 1991 and 1999 Indian Health Service dental screenings of American Indian/Alaska Natives).

The small number of children (n=21) in the Native Hawaiian/Pacific Islander results in wide confidence intervals, 
however the results on caries experience and untreated caries warrants further investigation of this racial/ethnic 
groups in future assessments. Asian children also experienced high rates of decay and lower sealant utilization. 
Some attention to prioritizing dental access strategies and dental sealant programs towards non-Native racial/ethnic 
minorities should be given in addition to ongoing efforts to reduce dental disease in Alaska Native children.

The survey indicates the state sealant utilization exceeds 50% (meeting the 2010 target as listed in Healthy People 
2010). Survey results indicate higher dental sealant utilization in AI/AN children even for those whose parents 
indicate are enrolled in the Medicaid/Denali KidCare program. Survey results indicate priorities for dental sealant 
programs should include outreach to Asian, Black/African American, Hispanic/Latino, Native Hawaiian/Pacific 
Islander racial/ethnic groups and to White children enrolled in the Medicaid/Denali KidCare Program.
ALASKA – Oral Health Assessment, 2005 (Kindergarten children)

Survey results listing the mean, confidence intervals and number of children in each category from the project for state totals, racial/ethnic groups and Medicaid enrolled children were as follows (2004/2005 school year – kindergarten):

<table>
<thead>
<tr>
<th>Category</th>
<th>Mean</th>
<th>Confidence Interval</th>
<th>Healthy People 2010 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Caries Experience</strong>:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (n=463)</td>
<td>48.2%</td>
<td>(43.5, 52.8)</td>
<td>42%</td>
</tr>
<tr>
<td>American Indian/Alaska Native (n=70)</td>
<td>75.7%</td>
<td>(64.0, 85.2)</td>
<td></td>
</tr>
<tr>
<td>White (n=295)</td>
<td>37.6%</td>
<td>(32.1, 43.4)</td>
<td></td>
</tr>
<tr>
<td>Other (n=98)</td>
<td>60.2%</td>
<td>(49.8, 70.0)</td>
<td></td>
</tr>
<tr>
<td>Medicaid/Denali KidCare (n=140)</td>
<td>59.3%</td>
<td>(50.7, 67.5)</td>
<td></td>
</tr>
<tr>
<td><strong>Untreated Caries</strong>:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (n=463)</td>
<td>24.6%</td>
<td>(20.8, 28.9)</td>
<td>21%</td>
</tr>
<tr>
<td>American Indian/Alaska Native (n=70)</td>
<td>37.1%</td>
<td>(25.9, 49.5)</td>
<td></td>
</tr>
<tr>
<td>White (n=295)</td>
<td>20.0%</td>
<td>(15.6, 25.0)</td>
<td></td>
</tr>
<tr>
<td>Other (n=98)</td>
<td>29.6%</td>
<td>(20.8, 39.7)</td>
<td></td>
</tr>
<tr>
<td>Medicaid/Denali KidCare (n=140)</td>
<td>32.1%</td>
<td>(24.5, 40.6)</td>
<td></td>
</tr>
<tr>
<td><strong>Caries Experience on Primary Anterior Teeth</strong>:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (n=457)</td>
<td>14.2%</td>
<td>(11.2, 17.8)</td>
<td></td>
</tr>
<tr>
<td>American Indian/Alaska Native (n=64)</td>
<td>28.1%</td>
<td>(17.6, 40.8)</td>
<td></td>
</tr>
<tr>
<td>White (n=295)</td>
<td>10.2%</td>
<td>(7.0, 14.2)</td>
<td></td>
</tr>
<tr>
<td>Other (n=98)</td>
<td>17.3%</td>
<td>(10.4, 26.3)</td>
<td></td>
</tr>
<tr>
<td>Medicaid/Denali KidCare (n=136)</td>
<td>19.1%</td>
<td>(12.9, 26.7)</td>
<td></td>
</tr>
<tr>
<td><strong>Treatment Urgency – Early or Urgent Dental Care Needed</strong>:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (n=463)</td>
<td>25.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian/Alaska Native (n=64)</td>
<td>41.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White (n=295)</td>
<td>20.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (n=98)</td>
<td>30.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid/Denali KidCare (n=140)</td>
<td>32.9%</td>
<td>(25.2, 41.3)</td>
<td></td>
</tr>
</tbody>
</table>
ALASKA – Oral Health Assessment, 2005 (Children Enrolled in Head Start)

Survey results listing the mean, confidence intervals and number of children in each category from the project for state totals, racial/ethnic groups and Medicaid enrolled children were as follows (2005 Head Start):

<table>
<thead>
<tr>
<th>Caries Experience:</th>
<th>NHANES (1988-94)***</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (n=571)</td>
<td>68.8% (63.9, 73.2)*</td>
<td>18%</td>
</tr>
<tr>
<td>American Indian/Alaska Native (n=423)</td>
<td>84.2% (80.2, 87.4)**</td>
<td>76% (IHS 1999)</td>
</tr>
<tr>
<td>White (n=54)</td>
<td>48.1% (34.3, 62.2)**</td>
<td>15%</td>
</tr>
<tr>
<td>Other (n=94)</td>
<td>45.7% (35.4, 56.3)**</td>
<td></td>
</tr>
<tr>
<td>Medicaid/Denali KidCare (n=351)</td>
<td>73.4% (67.2, 78.9)*</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Untreated Caries:</th>
<th>NHANES (1988-94)***</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (n=571)</td>
<td>40.5% (35.7, 45.5)*</td>
<td>16%</td>
</tr>
<tr>
<td>American Indian/Alaska Native (n=423)</td>
<td>50.8% (46.0, 55.7)**</td>
<td>67% (IHS 1999)</td>
</tr>
<tr>
<td>White (n=54)</td>
<td>24.1% (13.5, 37.6)**</td>
<td>11%</td>
</tr>
<tr>
<td>Other (n=94)</td>
<td>27.7% (18.9, 37.8)**</td>
<td></td>
</tr>
<tr>
<td>Medicaid/Denali KidCare (n=351)</td>
<td>42.5% (36.0, 49.0)*</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Caries Experience on Primary Anterior Teeth:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (n=570)</td>
<td>42.5% (37.6, 47.7)*</td>
</tr>
<tr>
<td>American Indian/Alaska Native (n=422)</td>
<td>60.9% (56.0, 65.6)**</td>
</tr>
<tr>
<td>White (n=54)</td>
<td>18.5% (9.3, 31.4)**</td>
</tr>
<tr>
<td>Other (n=94)</td>
<td>19.1% (11.8, 28.6)**</td>
</tr>
<tr>
<td>Medicaid/Denali KidCare (n=351)</td>
<td>49.8% (43.2, 56.3)**</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Urgency – Early or Urgent Dental Care Needed:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (n=571)</td>
<td>41.2% (36.3, 46.2)*</td>
</tr>
<tr>
<td>American Indian/Alaska Native (n=423)</td>
<td>52.0% (47.1, 56.8)**</td>
</tr>
<tr>
<td>White (n=54)</td>
<td>24.1% (13.5, 37.6)**</td>
</tr>
<tr>
<td>Other (n=94)</td>
<td>27.7% (18.9, 37.8)**</td>
</tr>
<tr>
<td>Medicaid/Denali KidCare (n=351)</td>
<td>43.6% (37.2, 50.2)*</td>
</tr>
</tbody>
</table>

* weighted data
** unweighted data
*** NHANES data is aged 2-4 years so not identical to this age group 3-5 years
Cavity Free Kids in Head Start: Training and Implementation One Year Later, Summary

NOVEMBER 2006
Cavity Free Kids in Head Start: Training and Implementation One Year Later, Summary

NOVEMBER 2006

Sylvan Robb, Senior Consultant

Prepared for
Alaska Department of Health and Social Services
Oral Health Program
130 Seward Street, Room 508
Juneau, AK 99801

Prepared by
Information Insights, Inc.
212 Front Street, Suite 100
Fairbanks, Alaska 99701
(907) 450-2450 phone
(907) 450-2470 fax

605 West 2nd Avenue
Anchorage, Alaska 99501
(907) 272-5074 phone
(907) 272-5076 fax

www.infoinsights.com
info@infoinsights.com
# Table of Contents

**Introduction**

**Programs that held a Cavity Free Kids training**

- Training status
- Who was invited and who attended
- Scheduling of trainings
- Use of curriculum agendas and PowerPoints, incorporation of local materials
- Easiest and most difficult sections of the curriculum to present
- Need for additional technical assistance regarding Cavity Free Kids
- Extent that Cavity Free Kids is being implemented in program
- Success stories
- Planned additional trainings
- Invitees for subsequent training
- Words of wisdom or lessons learned
- Other comments on Cavity Free Kids

**Programs that did not hold a Cavity Free Kids training**

- Status of training planning
- Reason programs have not held Cavity Free Kids training
- Technical assistance needs to accomplish Cavity Free Kids training
- Use of the curriculum
- Distribution of the curriculum
- Success stories
- Other comments on Cavity Free Kids

**Next steps**
Introduction

Over the course of a month from late August to late September 2006, efforts were made to interview the directors of all Head Start programs in Alaska regarding their use of the Cavity Free Kids curriculum. Staff from Head Start programs had attended a free train-the-trainer session on Cavity Free Kids in Anchorage in exchange for agreeing to offer the training in their community at least one time annually for the next two years. The train-the-trainer session in Anchorage was held in late October 2005, so programs were just coming to the close of their first year when they were contacted.

Short interviews were conducted with either the program director or whomever they designated as more able to speak about the Cavity Free Kids curriculum in their program. Nearly all programs were successfully contacted; all but three programs were reached and two of the three technical assistance providers for Alaska Head Start programs were interviewed.

Staff were asked whether they had held a training or not. For those who had conducted a training, information was gathered about the event and advice for subsequent trainings. Staff from those programs who had not held a training were asked what could be done to facilitate their training and what barriers had contributed to the training not being held yet.

The majority of programs had held a training. Those trainings ranged in length of time, depth of detail regarding the Cavity Free Kids curriculum and who was invited. Some programs devoted two days to the curriculum and others covered it in a few hours. Invitees ranged from just the program’s classroom staff to “everyone in the community with teeth”. All those programs who reported having held a training were implementing the curriculum to some degree.

Most of the programs reported planning to hold another Cavity Free Kids training. For those programs that had just held their training as part of the 06-07 school year preservice, they were taking a wait and see attitude regarding holding further trainings. Most staff reported that the curriculum was well received and easy to use. Respondents indicated that they found it well laid out and easy to use “right off the shelf”. Some programs did tailor the curriculum to be more specific to their community, adding local photos and data to the presentations. Other aspects of the curriculum that were appreciated were the sample letters to parents and newsletter articles.

For those programs who had not held a Cavity Free Kids training, many of the reasons were understandable. Several of the program directors were new to their programs; in one case the director had only been in her position for three weeks. Other programs were short staffed and just trying to keep the doors open. There were really only a couple programs for whom the reason they had not held a training was that this just was not a priority.

Overall, staff were very pleased with the Cavity Free Kids curriculum and impressed with the train-the-trainer session in Anchorage. Respondents grasped the importance of oral health and thought the curriculum was an excellent way to help improve the oral health of Alaska’s Head Start children.
Programs that held a Cavity Free Kids training

TRAINING STATUS

More programs than not had held a training although the notion of what constituted a training was as varied as the programs themselves. Some people held events that were more similar to what would traditionally be considered a training while others held open houses for the community. The trainings also ranged in length from a short presentation to a training over the course of several days. Those training included everyone from classroom staff, to all program staff, to parents, board members, and community members.

Among the nine programs that did hold a training about half of those programs did not hold their training until the pre-service for this year or until sometime this fall. Several programs who indicated they would be holding a training later this fall were motivated to meet their obligation or reminded of it by these phone calls.

Staff at several programs which had not held a training were either new to their program, had many new staff members to train on all manner of issues, or were short staffed and trying to keep their head above water without worrying about this.

WHO WAS INVITED AND WHO ATTENDED

Among the programs that held a training, about half invited some of the staff (generally classroom staff). Those programs that invited most of the staff tended to invite parents and community members in addition to all staff. Programs that chose not to include parents and community members made that choice for a variety of reasons. Several programs had travel difficulties since all their locations were not in the same community. Other programs held the trainings during the day, so thought it would be difficult for parents and community members to attend. Very few programs invited community members or those from WIC or other local health or dental programs. Among those who did, the only programs which had those types of people attend were those who had existing relationships with these providers (typically a dentist).

SCHEDULING OF TRAININGS

None of the programs held their trainings as an entirely separately scheduled event. The trainings were either held in conjunction with an outside meeting (at a conference, for example) or as part of pre-service training or a regularly scheduled in-service training. Three programs held the training during this year’s pre-service. Six programs held the training during a regularly scheduled in-service training day. All staff interviewed felt that it was easier to make time for the training by holding it during the regularly scheduled training times. Those who waited for the pre-service training indicated a
desire to ensure they had enough time to fully cover the material and that their in-service training calendars were scheduled for nearly the whole year at the beginning of the year. That made it difficult to include the Cavity Free Kids training prior to this year’s pre-service.

**USE OF CURRICULUM AGENDAS AND POWERPOINTS, INCORPORATION OF LOCAL MATERIALS**

Programs were more likely to use an agenda than not. Three programs used the agenda from the curriculum without modifying it at all. Three other programs used an agenda from the curriculum, but altered it to better fit the audience or to incorporate local materials. Two programs did not use one of the agendas provided, but instead created something from scratch to meet their training needs. Due to staff turnover and different locations for some programs’ sites, three programs didn’t know whether an agenda from the curriculum had been used. Staff from several of the programs that used the agenda without modifying it, thought that a strength of the Cavity Free Kids curriculum was that it was ready to go right out of the box.

More programs used the PowerPoint presentation, four total used an unmodified PowerPoint from the curriculum materials. Three programs modified a presentation to make it more appropriate for the audience they anticipated, or to included local data on oral health issues or local photos. Staff who used the PowerPoint felt that the photos included in the presentation were very powerful and made a good case for the need for oral health. Staff from only one program were sure they did not use it and that was due to a lack of equipment.

In addition to the local data and photos that programs incorporated into the PowerPoints and agendas, some programs incorporated other local materials into their presentation or activities. Some of the materials used included an oversized prop toothbrush and tooth, and some animal jaws and teeth from local animals. Those who didn’t incorporate local materials liked the fact that the curriculum could be used “as is” without needing to spend time locating materials.

**EASIEST AND MOST DIFFICULT SECTIONS OF THE CURRICULUM TO PRESENT**

Staff were very pleased with the curriculum and report that no section of it was difficult to present or for people to understand. Seven of the staff with whom we spoke reported no difficulties and four staff members had not personally been part of the training so were not sure if there were difficult areas. Staff reported no areas as being particularly easy to present since they found none of it difficult there was nothing to be easy by comparison. People reported really enjoying the activities and were pleased that there were portions of the curriculum geared for staff and parents. The sample letters and newsletter articles were very well received, although many people had not used them yet.

The only consistent complaint among participants was a minor one. One activity asks you to use vinegar on chalk to demonstrate how bacteria eat at the enamel on teeth. Staff reported difficulty finding chalk that was not low-dust chalk with a coating on it. The
activity does not work with the low-dust chalk. One program that tried many other things found that antacid worked well instead of chalk.

NEED FOR ADDITIONAL TECHNICAL ASSISTANCE REGARDING CAVITY FREE KIDS

Four of the 11 programs reported no need for additional technical assistance. Due to new staff and different locations, two programs did not know whether they might need more technical assistance or not. Five programs reported that they would like more technical assistance regarding Cavity Free Kids. In one case, the need was due to new staff who had not attended the training in Anchorage. Another staffer suggested that it would be great to revisit the Cavity Free Kids training at some point in the future to keep it fresh and current. One staffer suggested using the gathering at the ALPHA Health Summit to remind people about Cavity Free Kids and check in about how it is going for programs. Another staffer suggested that these phone calls asking about the program were a nice reminder to have a refresher with staff at the beginning of the school year.

Another staffer suggested that it would be nice to share what other programs who attended the training have done with the Cavity Free Kids curriculum. She felt it would be great to learn what types of trainings were held, who was invited and how the outreach was handled, what local elements people incorporated and what activities they found worked well.

EXTENT THAT CAVITY FREE KIDS IS BEING IMPLEMENTED IN PROGRAM

The majority of programs were using the ideas included in the Cavity Free Kids curriculum in their programs. Only one program was not using the information to any degree because they had substantial staff turnover and a federal review coming up and felt they just did not have time to worry about Cavity Free Kids. Two programs either had new staff or different locations so the staffer interviewed was not sure if the curriculum had been implemented at all.

The depth of the implementation ranged widely—from programs that had implemented just brushing and the ‘swish and swallow’ technique to those that were incorporating the full curriculum on a regular basis. Several programs had reached out to dental providers in their community and begun relationships that will continue to benefit the children in their programs.

SUCCESS STORIES

Five programs felt they had success stories, four programs did not and staff from one program was not sure. For the most part, those with success stories did not have stories about specific children, but reported that children brushed without being asked, were less afraid of visiting the dentist, went to the dentist more frequently, and loved to swish and swallow. One program did have a story of a boy who would not eat, was ornery and did
not get along well with the other children. After a dental screening, they found an abscessed tooth. Once that was treated, he was a very sweet child who got along well with the other children and ate normal amounts.

Another program who did not report any success stories nevertheless had one. The program reached out to their local dental community due to Cavity Free Kids and ended up with a local dentist on their board who comes to do exams on the children.

**PLANNED ADDITIONAL TRAININGS**

Five programs reported planning to hold another training while three reported it was too soon to tell at this point. Only two programs reported not having anything planned for this year. Among the programs that anticipate holding a training, there was a difference between those that held their training during the last school year and those that held their training during this fall’s pre-service or have it planned for sometime this fall. For those programs that held a training last year, they were more likely to describe a planned activity that sounded more like an update than a full scale training. Those programs who did not anticipate holding a training this year were those that had just held their training during this year’s pre-service. In essence, they had already had a training this year.

Some of those programs who had their training last year as well as some of the programs that held it during this year’s pre-service, mentioned an intention to use some of the curriculum materials (the parent letters and the sample newsletter selections) to remind parents about Cavity Free Kids and the importance of oral health for their children.

**INVITEES FOR SUBSEQUENT TRAINING**

Staff at two programs reported that they would invite the same people to a subsequent training. Both of these programs had invited a wide range of people before; one program invited all staff and parents while the other invited those people as well as community members and staff from local health care agencies. As the program director put it, “Anyone and everyone who has teeth, their own or otherwise.”

Staff from those three programs who indicated they would invite different people if they hold another training indicated they would invite those staff they were not able to be trained the first time they held training. In some cases these include newly hired staff, staff promoted to positions to enable them to implement the curriculum, and staff at other program locations. One staff member did indicate she would invite fewer staff members next time. However, this was due to logistics. Staff had to be flown in for an all staff training; this was only done every third year. So this year’s training will include fewer people.
WORDS OF WISDOM OR LESSONS LEARNED

When asked what they might do differently if they held another training or if they had any words of wisdom for programs that had not yet held their training, six of the 11 programs offered some advice. The other five programs were reluctant to tell other programs what to do. As one program director noted, all the programs in Alaska are so different and have very different resources and challenges; she wouldn’t want to think what worked for her would work for everyone.

Wisdom offered included advice to send more than one staffer to the training of the trainers. A program that only sent one person to the training lost that staff member, so now no one remains who has been trained in the curriculum. Another program offered advice more specific to holding a training; she stressed the importance of enthusiasm and suggested little door prizes make things much more fun. Staff from a second program also emphasized the importance of enthusiasm and promoting the Cavity Free Kids program every chance they got.

Other advice included trying to offer the training in smaller bite size bits to make it easier for people to attend. Too few people have two days free in this staff member’s opinion. She also suggested trying to make as much of the training hands-on as possible to keep people engaged and keep it from getting boring and preachy.

Advice for the training presenter was to review the notes included with the PowerPoint presentations. One staff member found the notes very helpful. She did not read aloud from them, but just had them in her head to use as talking points and had the information in her head to answer questions.

OTHER COMMENTS ON CAVITY FREE KIDS

Respondents were asked if they wanted to say anything else about Cavity Free Kids or oral health. Nearly all staff who were interviewed commented on either the importance of improving and promoting oral health or how wonderful the Cavity Free Kids curriculum is. Some people truly gushed about the curriculum; they loved how well it fit into Head Start culture and how easy it was to use. Everyone had good things to say about the curriculum and felt that the training had been an excellent opportunity and was very professional and enjoyable. Two respondents mentioned how nice it was that the training and materials were free and that they were welcome to make copies of the materials.

Those who mentioned the need for this curriculum and the state of children’s oral health in Alaska did the opposite of gush. Some staffers talked at length about the dismal state of the teeth of the children in their programs. Some noted that they have no access to dental care in their community or only a couple times a year. One program director noted with frustration that even though they had been working on oral health prior to Cavity Free Kids and even though they had embraced Cavity Free Kids, one of her teachers confessed to her that she still put her own baby down with a bottle with soda in it. She pledged to continue to spread the message and hope that it would sink in “the 15th time” that her teacher heard it.
Programs that did not hold a Cavity Free Kids training

There were seven programs that had not held a training at the time one of their staff members was interviewed. Among those seven, four were either planning to hold a training or anticipated holding one at some time this year. Three programs did not anticipate holding a training this year.

STATUS OF TRAINING PLANNING

Four of the programs who had not held a training either had one planned or anticipated holding one this year. Several programs either had the training already on their training schedule or were in the progress of compiling their training schedule and planned to include the Cavity Free Kids in the schedule.

Among those programs with no training planned or scheduled, one program director had been on the job for just three weeks. Another program was only Early Head Start and they were short staffed in addition to feeling like they had to work hard to translate what they had learned at the training to something appropriate for an Early Head Start program.

REASON PROGRAMS HAVE NOT HELD CAVITY FREE KIDS TRAINING

Among the seven programs who had not held the training, two had scheduled the training at some point but were forced to cancel it for some reason. One staff member scheduled the training twice and was bummed to allow time for other things each time. Two other staffers were very new in their positions and were still trying to get oriented. Neither staff member express any opposition to the idea and both hoped to be able to get the training off the ground once they settled into their position. One person had only been on the job a matter of weeks. The other three programs were all understaffed; one by 50%. One of these programs was struggling to prepare for a federal review and the other was an entirely home based Early Head Start.

TECHNICAL ASSISTANCE NEEDS TO ACCOMPLISH CAVITY FREE KIDS TRAINING

Programs were asked if there was any technical assistance Bonnie or Sarah could provide to help them meet their obligation to hold a training. Surprisingly only two of the seven programs said that technical assistance would make a difference in their ability to offer the training. Of the two that wanted technical assistance both had requests related to materials. One program had a new director who wasn’t sure they had the curriculum any more and wanted help getting a copy. The other program also had a new director who
thought they had the curriculum, but want help getting copies and reaching out to all her program sites.

Those programs who said it wouldn’t make a difference were either short staffed and felt they really couldn’t do anything until they hired more people. Other respondents felt they just needed to put the training on the calendar to committ them to holding it. One respondent noted it woud not help if Sarah or Bonnie came because the reason they have not trained is that staff are spread out all over in villages. If they could get people together for Sarah or Bonnie to visit they could get people together for a training.

**USE OF THE CURRICULUM**

Two of the programs are using the curriculum now and one was using it before. Four of the programs have never used the curriculum. Among the programs who are currently using the curriculum, in one multi-site program it was only being used in the classroom of the individual who attended the training in Anchorage. The other program, while not having a training, had included information about oral health in their newsletter and shared it informally with classroom staff. She was sure swish and swallow had made it into the classroom as well as an effort to serve less sugary snacks. The programs that was not using the curriculum now had distributed copies of portions of it and was ready to answer any questions that might arise.

Two of the four programs who were not using the curriculum at all were the programs with new directors where the curriculum could not be located. Another program was not using the curriculum because they had not been able to hire enough staff to open for the year, at the point when she was interviewed. The last program was not using the curriculum at all because he didn’t want to have people start using it in the classrooms until people had been properly trained.

**DISTRIBUTION OF THE CURRICULUM**

Given that the curriculum had not been widely shared with program staff at these programs it was not surprising that only one program had shared the curriculum with related personnel in the community. In that one case, the curriculum was not actually shared; a community clinic was offered the extra copy of the curriculum materials that were in the program but they did not want it (or did not come get it, it was not entirely clear which happened). The other programs had not been involved with the curriculum to a great degree, so they had not shared it with anyone else. Many staff did not seem to have even considered sharing it with other health care providers or educators in their community.
SUCCESS STORIES

Only one respondent had a success story; one of the new directors had fully implemented Cavity Free Kids in her old program. At her previous program, the children had fully embraced Cavity Free Kids and brushed and did the swish and swallow several times a day. One of her teachers had a good method for getting all children, even those as young as three years old, to brush their own teeth. The teacher would have all the children sit at a table to brush which was much less messy. The teacher would use a timer to keep the children brushing and they enjoyed making a game of it.

OTHER COMMENTS ON CAVITY FREE KIDS

Four of the programs reiterated that they thought Cavity Free Kids was a good program and they intended to try and hold a training and get the program implemented this year. Two programs mentioned wanting more training on the Cavity Free Kids curriculum. The only other comment received was the only negative comment about Cavity Free Kids. The staffer was from a program that was only Early Head Start. He felt that the training in Anchorage did not cover Early Head Start issues at all. He was struggling to figure out how to adapt the program to an entirely home based Early Head Start program.
Next steps

The next steps for the Cavity Free Kids program in Alaska’s Head Start programs are varied since the programs find themselves on a variety of steps at this point. For some programs who have held an in-depth training and implemented the program, their next step might be a friendly reminder to keep the program on the radar screen of busy staff. For those programs who have not held a training and have not implemented any of the Cavity Free Kids ideas or activities into their programs, their next step is to get a training scheduled and introduce staff to the curriculum. For the programs in between these ends of the spectrum their next step varies.

Given that nearly all the programs still have more they could do to fully implement and embrace Cavity Free Kids in their programs, the good news is that nearly all the programs want to embrace this curriculum and oral health. The biggest thing that will keep this program from becoming that thing that people remember doing a few years ago, is continued contact. Even a five minute phone call to see how it’s going and whether any help is needed will go a long way to keeping Cavity Free Kids in people’s minds and in their programs.

Other next steps include many of the ideas that staff members suggested. Sharing good ideas and tips regarding Cavity Free Kids between programs is a great idea. One excellent forum for that may be at the Alaska Public Health Association’s Health Summit. Staff members, both those who attended the training in Anchorage and those who did not, felt the training session was a great opportunity to get together with staff from other programs and trade ideas. The fact that the training was free was instrumental in allowing so many programs to participate. While, it is probably not feasible to hold another such event for Cavity Free Kids, perhaps a follow up teleconference might be scheduled.

The program will certainly be easier to support and sustain than some other efforts because staff responded so positively to the curriculum and understand the value of improved oral health.
CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

ORAL HEALTH FORUM

Friday • February 23, 2007

BP Energy Center • Anchorage, Alaska

Facilitated by
Charlie Johanson Adams
# Table of Contents

In Attendance .................................................................................................................. 1

Executive Summary ......................................................................................................... 2
  The Morning Session ...................................................................................................... 2
  The Afternoon Session ................................................................................................. 3

Priority Areas and Action Plans ........................................................................................ 6
  Priority #1: Financing Issues ......................................................................................... 6
  Priority #2: Access to Dental Services ......................................................................... 9
  Priority #3: Education of Parents/Caregivers/Providers ............................................... 11

Notes From the Brainstorming Session ............................................................................. 17
  Preventative Services .................................................................................................. 18
  Surveillance .................................................................................................................. 19
  Finance/Medicaid ......................................................................................................... 20
  Provision of Dental Services ....................................................................................... 20
  Dental Workforce/Training Issues ................................................................................ 22
  Access to Dental Services ............................................................................................. 23
  Education of Parents/Caregivers/Providers .................................................................. 24
  Solutions – Mentioned in Morning Session .................................................................. 25

CSHCN Forum Evaluation ................................................................................................. 27
## In Attendance

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steve Williams</td>
<td>Alaska Mental Health Trust Authority</td>
<td><a href="mailto:steve@mhtrust.org">steve@mhtrust.org</a></td>
<td>269-7697</td>
</tr>
<tr>
<td>Jayson Smart</td>
<td>Stone Soup Group</td>
<td><a href="mailto:smartjs@muni.org">smartjs@muni.org</a></td>
<td>343-4650</td>
</tr>
<tr>
<td>Rick Kunz</td>
<td>ANHC</td>
<td><a href="mailto:fredk@anhc.org">fredk@anhc.org</a></td>
<td>259-4661</td>
</tr>
<tr>
<td>Molly McGrath</td>
<td>DHSS Oral Health Program</td>
<td><a href="mailto:Molly_mcgrath@health.state.ak.us">Molly_mcgrath@health.state.ak.us</a></td>
<td>269-3400</td>
</tr>
<tr>
<td>Beth Kaplan</td>
<td>WCFH – EHDI</td>
<td><a href="mailto:beth_kaplan@health.state.ak.us">beth_kaplan@health.state.ak.us</a></td>
<td>334-2223</td>
</tr>
<tr>
<td>Cindy Christensen</td>
<td>DHSS</td>
<td><a href="mailto:Cindy_christensen@health.state.ak.us">Cindy_christensen@health.state.ak.us</a></td>
<td>334-2430</td>
</tr>
<tr>
<td>Cheri Scott</td>
<td>Stone Soup Group</td>
<td><a href="mailto:cheris@stonesoupgroup.org">cheris@stonesoupgroup.org</a></td>
<td>561-3701</td>
</tr>
<tr>
<td>Kathinka White</td>
<td>AOHP</td>
<td><a href="mailto:drkathinkawhite@yahoo.com">drkathinkawhite@yahoo.com</a></td>
<td>830-4238</td>
</tr>
<tr>
<td>Bonnie Lange</td>
<td>Foster Care Provider</td>
<td><a href="mailto:starblue@gci.net">starblue@gci.net</a></td>
<td>345-4618</td>
</tr>
<tr>
<td>John Cartwright</td>
<td>Parent</td>
<td><a href="mailto:John_cartwright@health.state.ak.us">John_cartwright@health.state.ak.us</a></td>
<td>334-2420</td>
</tr>
<tr>
<td>Pamela Hawk</td>
<td>ANHC</td>
<td><a href="mailto:PamelaH@anhe.org">PamelaH@anhe.org</a></td>
<td>257-4662</td>
</tr>
<tr>
<td>John Etter</td>
<td>ANMC</td>
<td><a href="mailto:jetter@scf.cc">jetter@scf.cc</a></td>
<td>279-2023</td>
</tr>
<tr>
<td>Susan Piakak</td>
<td>DSDS</td>
<td><a href="mailto:Susan_patiak@health.state.ak.us">Susan_patiak@health.state.ak.us</a></td>
<td>269-3603</td>
</tr>
<tr>
<td>Elizabeth Barnett</td>
<td>UAA – DH Program</td>
<td><a href="mailto:Barnett@uaa.alaska.edu">Barnett@uaa.alaska.edu</a></td>
<td>786-6426</td>
</tr>
<tr>
<td>Robin Gibson</td>
<td>Stone Soup Group</td>
<td><a href="mailto:RobinG@stonesoupgroup.org">RobinG@stonesoupgroup.org</a></td>
<td>561-3701</td>
</tr>
<tr>
<td>Royann Royer</td>
<td>Southcentral Foundation</td>
<td><a href="mailto:rroyer@scf.cc">rroyer@scf.cc</a></td>
<td>729-5162</td>
</tr>
<tr>
<td>Judy Oyler</td>
<td>Southcentral Foundation</td>
<td><a href="mailto:truitt@acs.alaska.net">truitt@acs.alaska.net</a></td>
<td>245-1032</td>
</tr>
<tr>
<td>Dorrie Wallis</td>
<td>SVR Health Center</td>
<td><a href="mailto:dorioval@aol.com">dorioval@aol.com</a> or <a href="mailto:dwallis@svt.org">dwallis@svt.org</a></td>
<td>235-0626</td>
</tr>
<tr>
<td>Thalia Wood</td>
<td>DHSS, WCFH</td>
<td><a href="mailto:thaliawood@gci.net">thaliawood@gci.net</a></td>
<td>269-3499</td>
</tr>
<tr>
<td>Stephanie Birch</td>
<td>DHSS, WCFH</td>
<td><a href="mailto:Stephanie_birch@health.state.ak.us">Stephanie_birch@health.state.ak.us</a></td>
<td>334-2424</td>
</tr>
<tr>
<td>Kathy Allely</td>
<td>Gov’s Council on Disability and Sp Ed</td>
<td><a href="mailto:Kathy_alley@health.state.ak.us">Kathy_alley@health.state.ak.us</a></td>
<td>269-8991</td>
</tr>
<tr>
<td>Richard Mandsager, MD</td>
<td>Children’s Hospital at Providence</td>
<td><a href="mailto:Richard.Mandsager@providence.org">Richard.Mandsager@providence.org</a></td>
<td>783-8540</td>
</tr>
<tr>
<td>Jim Singleton, DDS</td>
<td>ANMC Dental Clinic</td>
<td><a href="mailto:jsingleton@scf.cc">jsingleton@scf.cc</a></td>
<td>729-2000</td>
</tr>
<tr>
<td>Brad Whistler, DMD</td>
<td>DHSS, Oral Health Program</td>
<td><a href="mailto:brad_whistler@health.state.ak.us">brad_whistler@health.state.ak.us</a></td>
<td>465-8628</td>
</tr>
<tr>
<td>Sharon Schlicht, MPH</td>
<td>DHSS, Specialty Clinics</td>
<td><a href="mailto:Sharon_schlicht@health.state.ak.us">Sharon_schlicht@health.state.ak.us</a></td>
<td>269-3418</td>
</tr>
<tr>
<td>Jeannette Gorda, PHN</td>
<td>Fairbanks Regional Public Health Center</td>
<td><a href="mailto:Jeannette_gorda@health.state.ak.us">Jeannette_gorda@health.state.ak.us</a></td>
<td>451-1647</td>
</tr>
<tr>
<td>Delisa Culpepper</td>
<td>Alaska Mental Health Trust Authority</td>
<td><a href="mailto:delisa_culpepper@revenue.state.ak.us">delisa_culpepper@revenue.state.ak.us</a></td>
<td>269-7965</td>
</tr>
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*Delisa Culpepper (*not in attendance but on committee)*
Executive Summary

On February 23, 2007, the Children with Special Health Care Needs (CSHCN) Oral Health Issues forum was held at the BP Energy Center in Anchorage, Alaska. The forum’s purpose was to bring together individual parents, foster parents, practitioners, dentists, dental hygienists, policy makers, and funders to share their knowledge, expertise, strategic insights, and contributions toward the oral health care of children with special health care needs (CSHCN). The CSHCN Oral Health Forum was sponsored by The Stone Soup Group, Anchorage, Alaska, with support from a grant from the Association of State and Territorial Dental Directors and collaboratively planned by the Department of Health and Social Services, Division of Public Health, Section of Women’s, Children’s and Family Health, Oral Health Program staff members.

The Morning Session

The forum was designed to be delivered in two sections; the morning session was structured so that individual experts were given ten to 15 minutes to share their Alaskan perspective on the oral health issues that exist for children with special health care needs and their families. These individuals provided either a Power Point presentation and/or documented studies/notes regarding the issues. While the experts were presenting, the facilitator documented the issues and solutions as they arose. The documentation then served as a platform for the day’s work. The experts (in order of their appearance) are as follows.

<table>
<thead>
<tr>
<th>Experts</th>
<th>Perspectives</th>
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<tbody>
<tr>
<td>Dr. Richard Mandsager</td>
<td>Children’s Hospital at Providence</td>
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<td>Stephanie Birch</td>
<td>MCH and CSHCN Department of Health and Social Services</td>
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<td>Cindy Christensen</td>
<td>Medicaid Department of Health and Social Services</td>
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Panelists

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<td>Kathinka White</td>
<td>Parent</td>
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<td>Dr. Singleton,</td>
<td>ANMC Dental Clinic</td>
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<tr>
<td>Dr. John Etter</td>
<td>ANMC Pediatric Residency Program</td>
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<tr>
<td>Sharon Schlicht</td>
<td>Specialty Clinics Department of Health and Social Services</td>
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<tr>
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<td>Steve William</td>
<td>Alaska Mental Health Trust Authority</td>
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<td>Kathy Allely</td>
<td>Governor’s Council on Disabilities and Special Ed.</td>
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<tr>
<td>Elizabeth Barnett</td>
<td>Home Visitor</td>
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<tr>
<td>Judy Oyler</td>
<td>Home Visitor</td>
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<tr>
<td>Brad Whistler</td>
<td>Approaches in other states</td>
</tr>
<tr>
<td>Jayson Smart</td>
<td>Results of parents’ perspectives</td>
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</tbody>
</table>

Children with Special Health Care Needs (CSHCN) Oral Health Forum
Prepared by Charlie Johanson Adams • Leading EDGE Consulting
Ph: 907.688.3342 • Email: charlieja@pobox.mtaonline.net
During the morning session key issues, ideas, and solutions were documented and categorized into seven specific areas of priority. These seven areas of priority were determined by previous study of the prevailing research and the current planning strategies that the Department of Health and Social Services, CSHCN Division had been drafting. The seven areas of priority are:

1) Preventative Services  
2) Surveillance  
3) Financial/Medicaid  
4) Dental Services & Programs (Providing Services)  
5) Dental Workforce/Training Issues  
6) Education of Parents/Caregivers/Providers  
7) Access to Dental Services  

As the morning unfolded, clearly these seven categories were in line with the current status and issues as shared by the experts.

The Afternoon Session

During the working lunch hour, the participants reviewed the issues, and areas of priority discussed during the morning session and clarified each category’s documentation. This process set the tone for the afternoon’s work.

The afternoon session was structured for participants to work within individual mini-strategic planning groups. First as a larger group, the participants were asked to prioritize the seven categories down to three. (It was agreed upon that the four categories not selected would be secured for future development). The participants then determined which priority they wanted to independently work on throughout the afternoon; this small group then became the “working group” for each of the three priorities. The afternoon’s outcome was the development of an action planning document per priority. The participants identified the following categories as the three most important priorities to focus on over the next three years.

Priority #1: Financial/Medicaid Issues  
Priority #2: Access to Dental Services  
Priority #3: Education of Parent/Caregivers/Providers  

As the first step to action planning, the participants were asked to identify and select no more than one to two specific issues as documented under the prioritized category. Next they brainstormed all the possible action steps that were needed to successfully address each issue. This step seemed to be the most time intensive; however, once the steps were listed the group
could then align the action steps in order of priority, timeline, and responsibility (who is responsible for getting the action started and accomplished).
Throughout the afternoon the participants had the opportunity to “check-in” with each of the other groups regarding direction on their strategies and timelines. Often, there were areas within each of the action steps that could be “cross-walked” over to another group’s action plan.

This proactive approach was a positive spin away from reacting to a crisis then putting together a patch-work plan. Rather, the forum participants were treated to thorough, deeply sensitive, and “real” practices, experiences, and concerns as expressed by the guest speakers and panelists alike. In the final analysis of the day, the participants were able to hear each of the three group’s strategies, action steps, and direction. It was determined at that time to establish follow-up on a regular basis in order to keep the action plans moving forward.

Based on the evaluation (synopsis in appendix of report) of the day’s events, the participants were very satisfied with the CSHCN Oral Health Forum. They commented very positively on the organization of the forum, the productivity of the day, how the day’s time was prioritized, the direction of the facilitation, and the facility/location. Participation in the afternoon (in comparison to attendance in the morning) was a little more than half; and some participants noted they wished more had stayed for the afternoon. Ninety percent of the participants are interested in a follow-up meeting to work on the action plans. Participants acknowledged that by the end of the afternoon, “there was a direction for care and action steps to get us there” and that “this forum made us look at how discussion could become REAL.”
Priority Areas and Action Plans
WHERE DO WE WANT TO BE IN THREE YEARS?

Priority #1: Financing Issues
The following four strategies were determined by the participants after their thorough review of the issues, ideas, and solutions shared during the morning session:

Non-Kept Appointments or “No Shows”: Priority #1 as efforts are underway to address this issue. Regulation package for adult dental Medicaid services includes clarification that dentists can charge Medicaid recipients for non-kept appointments so long as it is the practice policy to charge all clients for missed appointments. Additionally, the department should explore a mechanism (e.g., use of D9999) to track non-kept appointments even though the Medicaid program would not be reimbursing providers for the missed appointments.

Increased Medicaid Dental Reimbursement: This is the highest priority identified of financing/Medicaid issues. It was felt that dentists and advocacy agencies need to encourage a Medicaid dental reimbursement increase. Medicaid reimbursement for most dental codes has not increased since 1999 using 1997 claim profiles. Historically, the department had tried to keep reimbursement at 80% of UCR (UCR = median charge). The current reimbursement level is typically 50-60% of median billed charges for dental procedures. It was also highlighted that the mechanism for dental reimbursement should be established in regulation (e.g., establishing new reimbursement rates every 3 years). Advocacy agencies that could work on building support for an increase include: Alaska Mental Health Trust Authority (AMHTA); Governor’s Council on Disabilities and Special Education; Alaska Chapter of the American Academy of Pediatrics, Alaska Chapter of American Academy of Pediatric Dentistry and Alaska Dental Society.

Liability Provisions in the Medicaid Provider Agreement: Some dentists and the Alaska Dental Society have expressed concerns with “hold harmless” language in the provider agreement. The provisions note the department is held harmless and that providers indemnify the department against any legal costs. Information from the Department of Law indicates this is standard language in state contracts and since the state is self-insured the Risk/Loss section would not support removing the language from the provider agreement. CSHCN Oral Health Forum participants felt it was worth the AMHTA and Governor’s Council to discuss with their legal consultants on any possibilities to change the hold harmless language – particularly the obligation for providers to be liable for any state legal costs should action be taken against the state in relation to the Medicaid program.

1115A Waiver: Several participants noted the Alaska Senate is contracting with Pacific Health Policy to draft an 1115A waiver for the Medicaid program. AMHTA and Governor’s Council could monitor the waiver and look at options in relation to dental services provided by Medicaid.
Additional issues, ideas, and solutions generated during the afternoon session:

- Medicaid reimbursement increase – update fee schedule.
- Federal law change to allow for co-pay (Title 19)
  - 1115A Waiver <AK Dental Society>
- Sliding fee scales (co-payment)
- Expansion of SCHIP – adding co-pay.
- Pressure needs to come from outside the state system to increase fee schedule.
- Regulations change to require a 2-3 year fee revision.
- SB Davis Bill: #3 W; Hollis French/#4 Dentists/AAPP/AAP, AMHTA/AAPP
- No show: take $ as a fine from PFD.
- Charging clients for no-kept patient (need for surveillance on numbers – we need data). MMIS new system.
- Implement extended adult dental.
- Increase payment/incentives for preventative care.
- Liability clause in provider agreement - “changing this” ← AMHTA influence.
- MH Trust involved with oral health care issues.
## Priority #1: Medicaid Financing

<table>
<thead>
<tr>
<th>Issue</th>
<th>Proposed Activities/Description</th>
<th>Outcomes</th>
<th>Timeline Start/Finish</th>
<th>Responsibility</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Non-kept appointments</td>
<td>• Regulation clarification billing to bill • Track non-kept appointments</td>
<td>• 3/2007 • 2-3 years: new system for Medicaid billing</td>
<td></td>
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<tr>
<td>2. Increase Medicaid Reimbursement</td>
<td>• Profile fees • Outside involvement - dentists • Legislative support budget issues</td>
<td>Done • FY 2009</td>
<td></td>
<td>Pediatric Dentists • Alaska Dental Society • Trust/Beneficiaries/Medicaid Recipients</td>
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<tr>
<td>3. Liability clause in provider grant</td>
<td>• Review other state’s liability • Dep’t of Law input • Involve outside agency to visit Governor/Legislative/Law to change language</td>
<td>Done</td>
<td></td>
<td>Alaska Mental Health Trust</td>
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<tr>
<td>4. Allow for co-payment, increase eligibility with co-payee 1115 Waiver, sliding fee schedule</td>
<td>• Waiver – set co-payments • Federal approval • Implement waiver</td>
<td></td>
<td>Legislature – Senate HESS • Consultant- DHSS • Governor’s Council on Disability and Special Ed. • Alaska Mental Health Trust Authority</td>
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</tbody>
</table>

**Children with Special Health Care Needs (CSHCN) Oral Health Forum**  
Prepared by Charlie Johanson Adams • Leading EDGE Consulting  
Ph: 907.688.3342 • Email: charlieja@pobox.mtaonline.net
Priority #2: Access to Dental Services

The following three strategies were determined by the participants after their thorough review of the issues, ideas, and solutions shared during the morning session.

1. Attention to Fee Schedule
2. Medicaid Co-Pay
3. House Bill #136 Support and Passage

Additional issues, ideas, and solutions generated during the afternoon session:

- SN dental clinic
- Case management.
- Childcare for siblings during appointments.
- Services available in-state, increase in DEC reimbursement rate.
- Home visits prior to appointments.
- Appointments outside traditional hours
- SN clinics in rural areas.
- Access to public transportation.
- Improving quality of care (knowing your patients better).
<table>
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<tr>
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<tbody>
<tr>
<td></td>
<td>• Update fee schedule</td>
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<tr>
<td></td>
<td>• Review fees periodically</td>
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<td></td>
<td>• Advocate federal law change</td>
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<td></td>
<td>• Get rid of “hold harmless”</td>
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<tr>
<td>Priority #2: Access to Dental Services</td>
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<tr>
<td>Support HB 136</td>
<td>• Gather info on Bill and disseminate</td>
<td></td>
<td></td>
<td>Cheri Scott (SSG)</td>
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<tr>
<td></td>
<td>• Request the GCDSE track HB 136</td>
<td></td>
<td></td>
<td>Ray Ann (SCF)</td>
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<td></td>
<td>• Distribute information to CSHCN OH Forum participants</td>
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<td></td>
<td>Kathy Allely (GCDSE)</td>
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<tr>
<td></td>
<td>• Additional training for hygienists to work with CSHCN</td>
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</tbody>
</table>
Priority #3: Education of Parents/Caregivers/Providers

The following three strategies were determined by the participants after their thorough review of the issues, ideas, and solutions shared during the morning session.

1: Parent/Caregiver Education
   ∇ Advocacy
   ∇ Oral health care
2: Design dental experience space
3: Promote continuity of care
4: Develop a guidebook

Additional issues, ideas, and solutions generated during the afternoon session:

α Fluoride varnish education.
α Information to parents on home care/tips that work.
α Information on recent technology.
α Parent friendly oral hygiene instruction.
α Culturally appropriate, respectful care.
α Parent and child will know what to expect from dentist and appointment and will be comfortable.
α Education that teeth can last a lifetime!!
α Parents will know there is a provider for their child.
α All parents know where to go.
α Providers adequately treat CSHCN (listen to parent).
α Education of providers on CSHCN.
α Advocacy training for parents.
α Outreach information will be available to all parents – “guidebook” access to oral health care.
α Education on questions to ask.
α Information to give providers.
α A space to experience dental office (Imaginarium)
α Health fair for CSHCN children and parents.
α Access to interpreters and educational materials in different languages.
α Transition from child to adult services – continuity of care.
### Priority #3: Education of Parents, Caregivers, and Providers of CSHCN

#### Guiding Principle: Teeth CAN last a lifetime

<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| Parent/Caregiver Education  
• Advocacy  
• Oral health care  
• What to watch for | • Pamphlets  
• Have a health fair for families with CSHCN  
• DVD on oral hygiene instruction  
• Instruction on fluoride varnish  
• Access to interpreters and educational materials in different languages  
• Get materials to schools/ILP to distribute to parents | Parents will have materials (information) to make informed decision regarding care. | | Thelia Wood – 269.3499 |         |
### Priority #3: Education of Parents, Caregivers, and Providers of CSHCN

*Guiding Principle: Teeth **CAN** last a lifetime*

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Dental experience</td>
<td>• Develop a non-threatening space for children to experience the dental office</td>
<td>Reduce anxiety for CSHCN and create a positive dental experience, reduction in parental stress</td>
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<tr>
<td>Issue</td>
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</table>
| Continuity of Care    | • Promote ongoing education regarding transition to adult services  
                       | • Parent education on requesting same provider for familiarity                     | Parent/family satisfaction and decrease in complex dental problems.      |                        |              |

*Guiding Principle: Teeth CAN last a lifetime*
### Priority #3: Education of Parents, Caregivers, and Providers of CSHCN (Page 4 of 4)

**Guiding Principle:** Teeth *CAN* last a lifetime

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Guide Book</td>
<td>• Develop materials (i.e. step-by-step resources book)</td>
<td>Parent/family satisfaction, timely access to appropriate care.</td>
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Children with Special Health Care Needs (CSHCN) Oral Health Forum • Action Plans
Prepared by Charlie Johanson Adams • Leading EDGE Consulting
Ph: 907.688.3342 • Email: charlieja@pobox.mtaonline.net
Notes From the Brainstorming Session

The following pages represent the brainstorming ideas and thoughts generated by the participants in the seven priority areas, (Preventative Services, Surveillance, Finance/Medicaid, Provision of Dental Services, Dental Workforce/Training Issues, Access to Dental Services, Education of Parents/Caregivers/Providers) as well as solutions mentioned during the morning session. It is the intention of the group that these notes are to be held for future work on the CSHCN Oral Health Plan.

An evaluation summary can be found at the end of this report.
Preventative Services

- Care coordination is an ongoing parental/caregiver need. (needs to be delegated).
- Combined dental with other procedures when children are under general anesthesia (noted concerns with long procedures, however Dr. Singleton noted some success with diagnostic procedures and dental).
- Coordination of medical and dental services for hospital-based care (e.g., under general anesthesia) is not always feasible but cases where it can be coordinated (See above).
- Need for a resource list for parents - updated and kept current.
- What can we do to get general dentists engaged?
  - Ideally pediatricians seeing CSHCN should be working closely with the dentists seeing these children. Connection between medical providers and pediatric dentists is pretty good but some examples that indicate need for greater awareness of pediatric dentists in treating CSHCN (possible Grand Rounds topic.)
  - Pediatric Dentists may not be the sole solution. Need to look for ways to inspire and encourage more general participation for children and adults with special health care needs/disabilities.
  - Medical/dental home “on campus” assists coordination of care (e.g., tribal programs)
  - Interaction between Pediatric Dentistry is improving, strengthening with time.
  - Noted concerns with prescribing medicines with sugar content, however want medicines that child is cooperative in taking (taste good).
  - Noted concerns with fluoride or chlorohexidine rinses if child swallows the rinses.
  - Train parents/caregivers on application of fluoride varnish for caries prevention (simple to teach painting the fluoride varnish on teeth.)

- One stop for dental needs (CSHCN Clinic) is a model used in some states (e.g., Pennsylvania). Likely an expensive model to pursue in Alaska to address CSHCN or adults with disabilities oral health issues.
- Repetitive treatment/repetitive visits – parents noted long wait times for both the dental visit and often once they are in the dental office (this can conflict with days the child is cooperative for dental treatment.)
- Advocating for increased dental rates (Medicaid) – could be a significant factor for continued dental practice participation in Medicaid.
- Other potential advocates for dental care for CSHCN include speech therapists and language/OT.
- Advocacy in the form of Parent Navigation for Native families.
- How to be a responsible patient – importance of keeping appointments (although group thought this was less of an issue with CSHCN due to difficulty getting appointments – but noted times when other medical issues/emergencies result in problems keeping appointments.)
- Continuity of care – seeing the same dentist each time means not having to utilize the first appointment time explaining the child’s condition, medications and history.
- The aging of dentists! – 25% of the workforce is age 55 and older and Dr. Singleton noted a similar distribution for pediatric dentists in Alaska (may be less access with retirements).
- Would like to hear what strategies work and what continues to be frustrations to help not only those that are highly motivated but others lacking these strategies.
- Private practitioner. Some private dental specialists are concerned about being promoted as the only specialist in his field who accepts Alaska specialists statewide for Medicaid patients and/or CSHCN (they feel they can handle their urban area but not statewide referrals.)
**Surveillance**

- Getting water fluoridation information to parents and providers.
- In sub-specialty and Neurodevelopmental mental clinic settings, start tracking incidence of dental cavities/hygiene issues. (Already noted in report – add to monthly report to WCF section.)
- Medicaid patient satisfaction survey.

- Parents of children utilizing a fluoride program without living in communities with fluoridated water.
- Survey percentage of children with healthy habits:
  - Tobacco
  - Soda pop
  - Candy
  - Bottle health
  - Nutrition
Finance/Medicaid

- Medicaid is working on a more quick turn-around time
- Medicaid problems have not changed much the last few years – still areas of the state with few private dentists participating in the program.
- No shows (non-kept appointments) are a huge loss to everyone. They cost provider’s downtime, restrict access to orthodontia. None in private practice in Fairbanks that accept care when providers reduce Medicaid participation and the children don’t get services.
- Tracking non-kept appointments in MMIS – Have discussed using a dental code to track “no-shows” in the claims processing system (e.g., use of D9999) without a reimbursement.
- Examples of practices with low “no show” rate with phone call reminders and other efforts to remind parents/caregivers and/or policies to discontinue seeing patients with repeated no shows. However, other examples of no show rates in tribal programs of 50-60%. No shows are likely a real (not just perceived) problem for dental offices.
- Shriners Hospital in Portland: Some parents have found additional accesses and services they could not get in-state at Shriners Hospital. Medicaid offers assistance with parent’s travel – Shriners assisting with other expenses. Noted services outside Shriners hospital are usually charged for and can be expensive.
- Rotational dentists not willing to work with Medicaid.
- Access to orthodontia - None in private specialty practice in Fairbanks that accept Medicaid.
- Private insurance may not cover ortho care; Medicaid only covers in specific circumstances (with cleft palate or Class III malocclusion and orthognathic surgery.)
- Routine access to dental services – Medicaid.
- Delayed cleft palate treatment (Fairbanks). No orthodontists in Fairbanks participating in Medicaid.
- Eligibility month-to-month (Medicaid) – problems when by the time the child gets an appointment they are not eligible for Medicaid.
- Reasons given for not getting involved in Medicaid:
  - Non-kept appointment issue; resulting loss of productivity and practice revenue.
  - Reimbursement issue – Medicaid reimbursement typically at 40-50% of billed charges.
  - Liability concerns – language in the Medicaid provider agreement indicating provider is responsible for any state legal costs if the state brought into Medicaid related lawsuits
- Medicaid reimbursement for most dental services has not increased since 1999 using 1997 claims data (10 years from current rates).
- Some states (e.g., New Mexico) provide a case management fee in addition to dental Medicaid reimbursement to compensate providers for additional time treating CSHCN in their dental offices.
- Most dentists enrolled in Medicaid as the program has not dis-enrolled providers that are not active – about 50-70 private practices participate in Medicaid at a level of $10,000 + in paid Medicaid claims (most pediatric dentists are high-end Medicaid providers)
- Bills to watch: increase in DKC with co-pay. 200-300% poverty.
- Excess Medicaid receipts (at $10,000) most in Anchorage, 3 Fairbanks, 1 Bethel, 1 S.E., 2/3 from Anchorage.
- Confusion between Denali KidCare and Medicaid perception! Some providers indicate they accept DKC but not Medicaid (DKC is a higher income group under SCHIP but it is a Medicaid expansion)
- Review of DKC dental utilization indicates children in these higher income families have greater dental access than the traditional Medicaid program (Title XIX).

Provision of Dental Services

- Parents/caregivers feel like second class
- Need to have everything in order to receive
citizen in some provider offices – perception they are “taking from the system.”

- Some parents have experienced long wait times in provider offices – other children coming later that were seen first while they were kept waiting.
- Going out of state is a real burden. Locally who is available? Many doctors are booked way ahead.
- Getting a large wheel chair into a clinic environment – dental operatory can be a barrier to care.
- Rural issues: once they come to town, going to the appointment. No rural care.
- Rural issues: Services that are available in Anchorage are often not available in rural areas. Some rural families are unwilling to relocate family/child to Anchorage for long periods of time for surgeries (e.g., cleft palate cases).
- Challenging settings can create behavior problems and/or fearfulness - noise (drills, others crying, etc.)
- Dental care is one of many issues in the child’s life, yet they are all linked.
- Many schedules and situations have to line up to get care: provider scheduling, work, child care availability for other children, medical appointments and a day that behavior/compliance is not going to be an issue.
- Difficult to get all issues diagnosed. Costs are high.

- Multitude of appointments for CSHCN – parents must prioritize children’s appointments.
- Dental access typically Monday through Friday services only – few dental providers have Saturday hours.
- Barriers: big systems, no routines and scheduling patterns.
- Don’t focus only on what is available in Anchorage. Rural areas have oral health issues.
- Poor water quality in some rural Alaskan communities - easy to drink soda or fruit drinks instead. Sugar → cavities.
- Pediatric Dentistry requires more training (additional time and debt for extra years training in this specialty.)
- Pediatric dentists are typically high-end Medicaid providers and the major source of dental care for CSHCN. ANMC-Southcentral Foundation, with support from Lutheran Health Systems, has started a hospital-based pediatric dental residency program that offers great potential for increasing the number of pediatric dentists in Alaska (currently 13-14 pediatric dentists.)
- ANMC-Southcentral Pediatric Dental Residency Program trying to build a good foundation of education/training for treatment of CSHCN.
- Training of general dentists to see CSHCN and/or adults with disabilities may be the issue limiting access to these providers.
Dental Workforce/Training Issues

- University clinic will have access for CSHCN.
- Free training: NMC Oral Health Association (or is this the MCH National Oral Health Resource Center training?).
- Use community based entities to raise awareness of dental issues and do screenings. Example – beautician trained about strokes.
  - Church BINGO, Daycares, Message on date stamp on photo
- Examinations: How do we do this on a regular basis? What is frequent? CSHCN need may need more frequent exams.
- Are there good textbooks that focus on CSHCN?
- Training for dental assistants and dental hygienists/hygienist also important. Expose students to CSHCN especially in the child’s home setting.
- Private specialty practice (orthodontists) do not want to take Medicaid cases outside of Anchorage hub clients (stated they can’t be the referral center for the entire state.)
- Knowledge has decreased with fluoride in water systems in rural Alaska.
- Start with easy first, and then move on to more complex!
- Training and expertise needed within state – look at services that CSHCN are having to go out-of-state for (e.g., Shriner’s Hospital).
- Instill in students the “service” belief skill set. Sense of responsibility.
- Community Health Aide training program (include dental). Possible to increase preventive services in rural Alaska – assist parents/caregivers.
- Educating providers: sensitivity training.
  - Are they ready to provide compassionate care?
  - Do they have the time?
Access to Dental Services

What action steps will be necessary to get there?

α Study other states’ action plans (PA and NM) for SN Dental Clinic.

α Explore the possibility of regional hubs.

α Explore funding around case management.

α Distribute information on HB 136 (rroyer@scf.cc)

α Seek funding source.

• Mobile units: just imagine the potential – assist with home based dental services, topical fluorides, etc.

• Home/house calls. More at ease at home, familiar and practical for child (children often fearful and leads to behavior difficulties in the dental office.)

• University dental assisting/hygiene school is a good resource – could be used to assist more (e.g., appointments for cleanings.)

• Engaging dental hygienists with CSHCN.
  o Move out into community.

• Supporting HB 136 as a potential for dental help coming to you (bill to allow for more hygiene functions under general supervision in underserved settings.)
  o Goal: Blessing of dental society and/or Board of Dental Examiners to support traveling dental hygienists.

• Someone to help – just to figure all this out (parent resource and/or case managers)

• ANMC residency program has seen increase access to care. Months to 2-3 weeks.

• Dental “presence” in the community is seen as extremely important.

• Supports in place for families: assistance with Medicaid enrollment, getting to appointments, etc.
  o Surgeries/appointments on Saturdays, evenings would help.
  o Finding providers who take Medicaid and will see CSHCN.
Education of Parents/Caregivers/Providers

- Parent’s education of oral health needs.
  - Sugar in medications – are there alternatives that still taste good.
  - Recognition of enamel caries
  - Training on use of fluoride varnish
  - Monitor and assist with brushing
  - Use of battery operated toothbrush and/or floss aides
- Parental confidence with approaches – assisting brushing, fluoride varnish and other preventative measures.
- Transportation: more flexible appointment times, consideration of medications and behavior (am or pm better.)
- Non-English speaking parents.
  - What is available to help them?
- Constantly putting out fires – need assistance managing given medications, other medical appointments, transportation issues, etc. – case management assistance.
- Parents having skill sets.
  - We are the teachers.
- Some studies indicating CSHCN have two times more unmet oral health needs.
- Children often not seen prior to five to seven years old. No access for young – DKC issue (referral by age one) and provider issue with accepting younger children.
- Exams can be more difficult for children under three years old.
- Questions from health providers about compliance.
- Multiple developmental issues:
  - Swallowing
  - Choking
  - Gastroesophageal reflux
  - Gag reflex
  - Difficulty brushing/flossing
- Behavioral issues with brushing teeth:
  Where’s the priority? Shoes on? Teeth
- Daily start over – battling with not wanting anything in their mouth. Parents often have to do what they can at the time – can’t always get everything done especially on days when child is not cooperative. (Do what you can at the time.)
- More than one generation with developmental disabilities (parents and children) – complex issues in families with more than one child and/or adult with a disability.
- Education of new Medicaid eligible clients regarding value of appointments and physicians, dentists, AMP, etc. Importance of keeping appointments.
- Literacy programs for dental care include; Asian, Hmong, Alaska Native, Am. Indian, Hispanic, Hawaiian/Pacific Islanders, African American/Black, etc.
- Dental decay and relation to other chronic diseases (e.g., diabetes.)
- Medications – sugar content, decrease saliva flow and/or hypertrophy of gingival (dilantin seldom used anymore).
- Exposure to general anesthesia – sedation.
- Education and linkages: oral health issues can affect speech and language development. Also, may affect dietary choices.
- Parent housing/assisting children from rural Alaska has seen a number of children that have never had a toothbrush in their mouth. Hard to get them to start brushing if the habit hasn’t been established – tries integrating them in with when other children are brushing.
- Risk issues:
  - Child safety
  - Provider safety
  - Environmental safety
- Oral issues and medications. Have adverse conditions.
brushed?

**Solutions – Mentioned in Morning Session**

- Fluoride varnish – training of parents; done by medical providers; fluoride varnish is Medicaid reimbursable for dental providers but not medical providers at this time.
- Teeth should be a higher priority for CSHCN – often overwhelmed by medical concerns and medications!
- Mobile units: just imagine the potential.
- Governor’s Council is willing to work on dental care health issues.
- 13 Pediatric Dentists in Alaska.
- Asking parents on oral health practices – what has worked (e.g., fluoride rinses, battery-operated toothbrushes, etc.)
- Limited funding is available at federal level. Need for more research on products, what works, etc.
- Supporting House Bill 136 as a potential for dental help coming to you – bill authorizing more dental hygienist practice under general supervision.
- Streamlining takes time and patience.
- University dental assisting/hygiene school is a good resource – could be used to assist more (e.g., appointments for cleanings.)
- Dental “presence” in the community is seen as extremely important.
- Identify patients and help with community dental care needs as a community issue.
- Incentives for prevention.
- Supports in place for families, Medicaid, getting families to services on time; use of a navigator.
- Transition from child to adult dental services.
- Finding providers who take Medicaid. Donated dental program offers some access (includes donated lab fees in addition to treatment.)
- ANMC residency program has seen an increase access to care: months to 2-3 weeks.
- Dental health fair for CSHCN and their parents (families)
- MH Trust involved with oral health care issues.
- Surgeries and/or dental appointments on Saturdays or evenings would assist parents/families.
- Most dentists are enrolled in the Medicaid program – but only 50-60 private practices participate at a significant level in the program.
- Someone to help; just to figure this all out.
- Familiarity with the same provider. Assists in provider working with child, can assist in child cooperation/comfort with dental office and avoids repeating long medical histories.
- Coordination of services.
- Dedicated time from beginning to end of the process.
- Mobile dental care.
- Interpreters for families.
- A manual for dental health care for CSHCN
- Guardianship for adult CSHCN.
- Medicaid is key to supporting our adoptive children.
- Imaginarium has a pretend dental suite.
- Home/house calls. More at ease, familiar and practical for child.
- Getting dropped. I don’t know everything.
- A space to experience the dental office. Get children comfortable with the dental environment without using appointment time for that.
- Need more available resources to assist with home care, working with dental offices and parent information.
• Some solutions may be simple – Smiles say it all.
CSHCN Forum Evaluation

Total Evaluations Collected: 11

What was your overall reaction to the CSHCN Forum?

Please rate the following:

- Clarity of Goals for the Forum
- General Level of Participation at Forum
- Organization of Forum
- Productivity of Forum
- Adequate Time for Discussion
- Forum Facilitation
- Facility & Location

Comments:

- Creative and interesting; proactive discussion
- Rushed for a one-day meeting, but overall good participation and energy.
- Great job, Charlie!
- We covered a LOT of ground. Thanks for the great facilitation.
- Good location, but cool in the room.
Was an agenda provided before the meeting?

Were materials provided during the meeting? Yes (10)

If yes, were they useful? Yes (10)

Why/Why not?
- Fun!
- Survey information helpful
- Good overview of issues
- Made it easier to take notes
- Identified the issues
- Sticky notes 😊

Was the presentation(s) informative and useful? Yes (10)

Why/Why not?
- Gave a good perspective
- As pertains to needs (real needs, at hand)

Was the afternoon discussion informative and useful? Yes (9) No response (1)

Why/Why not?
- Round table should identify one facilitator and have more organization. May identify experienced facilitators to each group prior to the assignment.
- I wish we had stayed
- A little too much downtown
- Some dip in energy but okay
- But hard to narrow down a top priority
- It made us look at how discussion could become “real”

Would you be interested in a follow up meeting to work on an Action Plan?

Children with Special Health Care Needs (CSHCN) Oral Health Forum
Prepared by Charlie Johanson Adams • Leading EDGE Consulting
Ph: 907.688.3342 • Email: charlieja@pobox.mtaonline.net
| Yes (9) | No response (1) |
Suggestions for future meeting topics:

• Work on priorities and action plan as a group, not roundtable
• Successes and failures of action plans
• Need to get most of the same people back so didn’t have to revisit issues
• Follow-up meeting to inform on progress

Other Comments/Suggestions

• Include rural area providers and community health aides and families; outside professional groups
• Thank you!
June 30, 2007

To: File

From: Brad Whistler, DMD, Dental Officer; and
Sharon Schlicht, Health Program Manager (Statewide Sealant Coordinator)

Subject: Information on dental sealant inventory and estimated sealant rates for eligible and non-eligible Alaska elementary schools.

Needs Assessment/Plan for a State Sealant Program:

The FY2007 “Notice of Grant Award” included funding for 0.25 FTE of the Health Program Manager II/Program Coordinator, however with changes in the department’s indirect rate and increased contributions to fringe benefits the cooperative agreement funding only supported existing staff: 0.75 FTE Dental Officer, 1.00 FTE Health Program Manager II (Fluoridation Specialist/Health Educator/Coalition Support – Molly McGrath) and 0.5 FTE for Health Program Manager II (Fluoridation Specialist). The result was that duties for management of professional services contracts and assistance with the program budget and expenditure reports were shifted from the Dental Officer to HPM II Sharon Schlicht – effectively reducing her time on working with activities related to school based/linked dental sealants from the funded 0.5 FTE to less than <0.25 FTE. Further, as a clarification it is not anticipated that the Oral Health Program will undertake direct provision of dental sealants as it is cost-prohibitive given transportation expenses in Alaska and department policy has shifted from program inclusion of direct services to administration/policy activities supporting private and/or non-profit sector provision of direct services. The Oral Health Program anticipates working with tribal and community health center dental programs to expand availability of school-based/linked dental sealants to “eligible” schools (Note: eligible schools as defined in the Children’s Dental Health Improvement Act.) The Oral Health Program would also serve for data collection and evaluation aspects related to these sealant programs as they are implemented.

The program initiated a professional services contract in 2005 to inventory existing school-based/linked dental sealant programs and list eligible schools as defined in the “Children’s Dental Health Improvement Act” – rural schools in communities with a median income at or below 235% of federal poverty level and urban schools with 50% or greater of children enrolled in the free and reduced school lunch program.

The following provides a summary from the sealant inventory:

- **Total schools & eligible schools with third graders:** 359 total schools; 234 rural; 125 urban; 214 eligible rural schools; 61 eligible urban schools; 275 total eligible schools.

- **Schools with a sealant program:** 165 total schools; 151 rural eligible schools; 14 rural ineligible schools.

- **Percent of schools with a sealant program:** 165 total programs/359 total schools = 46%; 151 eligible schools/275 total eligible schools = 55%.
• Number of 3rd graders in schools with a program: 1,000 rural eligible + 216 rural ineligible = 1,216 rural 3rd graders; 1,000 rural eligible + 216 rural ineligible + 0 urban = 1,216 total 3rd graders; 1,000 rural eligible + 0 urban eligible) = 1,216 total eligible 3rd graders.

• Percent of 3rd graders in schools with a program: (1,000 rural eligible + 216 rural ineligible)/2,287 rural 3rd graders = 53%; (1,000 rural eligible + 216 rural ineligible + 0 urban)/8,404 total 3rd graders = 14%; (1,000 rural eligible + 0 urban eligible)/4,314 total eligible 3rd graders = 23%.

• Number of sealants placed in school-based/linked dental programs: Information was not collected and is not available through another source at this time. In the future information could be collected from the tribal programs providing sealants to village schools. The Oral Health Program could also ask the tribal programs to collect/report on sealant retention rates.

• Number of eligible schools without a program: 63 rural schools + 61 urban schools = 124 total schools.

• Percent of eligible schools without a program: 63 rural schools without a program/214 rural eligible schools = 29%; 61 urban eligible schools without a program/61 urban eligible schools = 100%; 124 total eligible schools without a program/275 total eligible schools = 45%.

• Number of 3rd graders in schools without a sealant program:
  - ((14 + 767 + 219 rural eligible schools with a sealant program) + (5 + 75 + 136 rural ineligible schools with a sealant program) + (0 urban schools with a sealant program))/8,404 total 3rd grade children = 14%; percent of total 3rd graders without a program = 86%.
  - (14 + 767 + 219 rural eligible schools with a sealant program) + (5 + 75 + 136 rural ineligible schools with a sealant program)/2,287 total 3rd grade children in rural schools = 53%; percent of rural 3rd graders without a program = 47%.
  - (14 + 767 + 219 rural eligible schools with a sealant program)/1,886 total 3rd graders in eligible rural schools = 53%; percent of rural 3rd graders in eligible schools without a program = 47%.
  - 0 urban schools with a sealant program; percent of urban 3rd graders in eligible schools without a sealant program = 100%.

• Percent of 3rd graders in schools without a sealant program:
  - ((14 + 767 + 219 rural eligible schools with a sealant program) + (5 + 75 + 136 rural ineligible schools with a sealant program) + (0 urban schools with a sealant program))/8,404 total 3rd grade children = 14%; percent of total 3rd graders without a program = 86%.
  - (14 + 767 + 219 rural eligible schools with a sealant program) + (5 + 75 + 136 rural ineligible schools with a sealant program) + (0 urban schools with a sealant program))/2,287 total 3rd grade children in rural schools = 53%; percent of rural 3rd graders without a program = 47%.
  - (14 + 767 + 219 rural eligible schools with a sealant program)/1,886 total 3rd graders in eligible rural schools = 53%; percent of rural 3rd graders in eligible schools without a program = 47%.
  - 0 urban schools with a sealant program; percent of urban 3rd graders in eligible schools without a sealant program = 100%.

• Estimated third-grade sealant rates (utilizing 2004 BSS data of third-graders):
  - Rural eligible schools with a program: 72%
  - Rural eligible schools without a program: 55%
  - Rural ineligible schools: 64%
  - Urban eligible schools: 40%
  - Urban ineligible schools: 53%
  - Statewide sealant rate: 52.4% (2004)
Discussion and Oral Health Program Sealant Plans:
The inventory project and BSS data support the Oral Health Program intended efforts to work with tribal and community health center dental programs for implementation of new school-based/linked dental sealant programs in eligible schools. The greatest number of third-grade children would be served by implementation of sealant programs in eligible urban schools; these schools also have the lowest overall estimated sealant utilization. Fourty-six of the sixty-one eligible urban schools are within the service areas or nearby on road systems to existing community health center dental programs in Anchorage, Fairbanks, Kenai and Talkeetna, therefore collaboration with the community health centers seems a logical approach to implementing sealant programs in these schools.

The estimated sealant utilization in rural eligible schools is the highest of the categories at an estimated 72%. This high sealant utilization is the result of tribal dental programs providing sealant-focused and/or sealants as part of routine comprehensive dental care in these schools through a school-based and/or school-linked approach. Sealant focused programs in these schools are in addition to comprehensive dental programs from the tribal organizations. The sealant utilization rates in rural ineligible schools and rural eligible schools are also influenced by the percentage of Native children and the related tribal dental programs. Many of the rural eligible schools without a program are in regional “hub” communities within the Native health corporation service delivery areas such as in Nome, Bethel, Dillingham, Ketchikan, Kodiak and Sitka. These larger regional hub communities often have a high percentage of Native children but the tribal programs don’t deliver care in a school-based or school-linked approach as the schools is racially mixed with significant numbers of children that are not eligible for Indian Health Service benefits. Sealant programs in these schools could evolve with collaboration of the tribal programs with the state presence of the Oral Health Program participating in the development of these programs, however these communities also have private dental practices and given the population size of the community there will be some issues with fears of government-sponsored competition with private practice.

There are also rural, eligible schools in communities that are largely Caucasian in racial/ethnic demographics and that do not have a strong connection to the tribal health programs – examples include Cantwell, Cordova, Glennallen, Petersburg, Tenakee Springs and Thorne Bay. These rural, eligible schools will pose the greatest logistical issues in development of school-based/linked sealant programs. A possible alternative will be to look at dental professional service contracts if/when a funding source is identified.

Medicaid reimbursement for sealants could play a major role in the feasibility and sustainability of the proposed sealant programs. Community health centers are paid on an encounter based reimbursement at this time and the encounter rate could easily support both the sealant placement and later evaluation for sealant retention, however Medicaid policy indicates that Medicaid cannot be billed for a service provided to Medicaid recipients if similar groups are not charged for the same services. Most states have handled this issue through state general fund allocations or foundation funding to cover the sealant charges to children whose families can’t pay for the services (but aren’t Medicaid/SCHIP eligible). There is not a mechanism in place in Alaska at this time to address this Medicaid policy issue. Incrementally, the Oral Health Program is looking at implementing a sealant program without charging for the services with Community Health Centers and/or the University of Alaska dental hygienist program contributing the resources as part of community outreach. This will allow the stakeholders and Coalition to evaluate other logistical and policy issues with implementing sealant programs. It is also hoped that with these “pilot” programs the Coalition can build support for funding to address payment for sealants for children from low-income families that can’t pay for the sealant charges. Discussions with the coalition, university and community health centers are discussing piloting the first program in Anchorage.