



# Oregon Children's Dental Health Initiative

Evaluation Progress and Findings

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Fall 2016



This report summarizes the Oregon Children's Dental Health Initiative evaluation progress and findings as of fall 2016. It is organized in three sections that are aligned with the strategies of the Initiative and the Initiative evaluation questions:

1. Education and engagement: How and to what extent do Initiative activities result in action among key groups in Oregon?
2. Funding for community-based organizations: How and how well are community-based prevention programs able to demonstrate how oral health care can be provided in an expanded health-care system?
3. Leadership and advocacy: How do Initiative efforts contribute to policy, funding and systems changes?

Each section contains both an evaluation progress update describing the methods used to date and findings that detail what we have learned thus far.

Opportunities for furthering the goals of the Initiative (and its evaluation) are highlighted at the end of each section (in green).

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Cover photo: Kemple Memorial Children's Dental Clinic

# INTRODUCTION

## About the Initiative

The Oregon Children's Dental Health Initiative was launched in 2014 by The Oregon Community Foundation to address the statewide crisis of childhood dental disease in Oregon. After declaring children's dental health a strategic priority for the Foundation, the OCF board committed \$2.5M over five years to this Initiative, with the majority of dollars earmarked for community programs that provide prevention services to children. With partners, OCF seeks to reduce children's dental disease statewide through three strategies:

1. Education and engagement: Increasing awareness of children's dental disease and promoting children's dental health.
2. Funding for community-based programs: Increasing access to school-based dental health services and increasing the number of medical professionals who actively screen for oral disease.
3. Leadership and advocacy: Providing a leadership role in shaping the state's policies and procedures to significantly improve children's dental health in Oregon.

The Initiative's goal is to build private and public partnerships to improve children's dental health across the state. Several funding partners joined in the effort in 2015 and 2016, specifically to support the school-based dental health services piece of the Initiative. More information about each strategy is included at the top of each section of the report.

## About the Evaluation

The purpose of the Oregon Children's Dental Health Initiative evaluation is to assess the effectiveness of Initiative activities and track progress toward the goals of the Initiative.

The Initiative and evaluation are now effectively at their midpoint. Thus far, we have focused on building understanding of the complex context in which the Initiative is operating and seeking opportunities to support system improvement. This work includes ongoing engagement with the Oregon Health Authority (OHA), a review of existing data and analysis of the policy environment related to children's dental health. The evaluation team has produced several prior reports to share knowledge gained through this work, including:

- **Status of Children's Dental Health in Oregon:** A report summarizing the status of children's oral health in Oregon, based on data available at the time (late 2014)
- **Oral Health Policy and the Delivery of Care:** A policy brief describing the structures that support children's dental health and related policy changes (late 2015)

In the past year, the energy of both Initiative and its evaluation has concentrated on the launch of funding for school-based prevention programs (and data collection regarding those programs). As a result, the bulk of the findings included relate to prevention program efforts. However, information is included about all three strategies of the Initiative.

# EDUCATION AND ENGAGEMENT

## INITIATIVE AND EVALUATION PROGRESS

Initiative efforts related to education and engagement include partnership development with other funders and stakeholders, engagement of OCF dental health champion volunteers, collaboration and coordination with the Oregon Health Authority (OHA), and support for education efforts such as dental kit building and distribution and the integration of oral health into other OCF initiatives. The evaluation of this strategy documents the progress made to date regarding these efforts.

**Evaluation Question #1**

*How and to what extent do Initiative activities result in action among key groups in Oregon?*

## FINDINGS

### 1 OCF is successfully engaging partners to fund the Initiative.

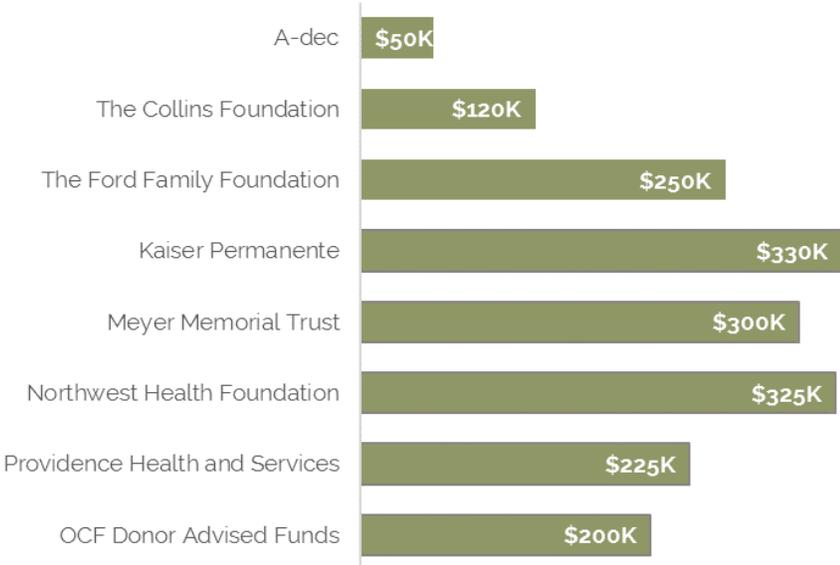
In addition to the almost \$2.5 million in OCF discretionary funds committed to the Initiative, six funding partners have committed a total of approximately \$1.6 million to date. Funding partners now include A-dec, The Collins Foundation, The Ford Family Foundation, Kaiser Permanente, Meyer Memorial Trust, Northwest Health Foundation and Providence Health and Services.

### 2 Individual donors have also contributed to the Initiative.

OCF Donor Advised Fund commitments now total almost \$200K. OCF staff have promoted the Initiative as a way to engage donors. Individual contributions can also be attributed to the outreach done at OCF Leadership Council meetings and other opportunities where examples of specific projects can be shared to increase support locally.

**Additional investments almost double the total commitment made to date, combining \$2.5 million in OCF discretionary funds with \$1.8 million from funding partners and OCF donors.**

*Initiative funding commitments to date*



## EDUCATION AND ENGAGEMENT continued

### 3 Dental health champion volunteers are engaged in efforts like building and distributing dental kits and supporting water fluoridation.

In 2014, almost 50 OCF volunteers self-selected as potential dental health champions — those interested in supporting Initiative efforts. These volunteers assemble dental kits, present grant checks and volunteer on steering committees for local school-based prevention programs. A few volunteers also step up regularly to advocate for local water system fluoridation. In addition, OCF staff engage in the annual Mission of Mercy free dental care clinic coordinated by the Oregon Dental Association.

### 4 Assembly and distribution of dental kits continues to be a successful method of engagement and education.

OCF uses dental kit assembly and distribution projects as a way to engage dental health champions (or help them engage with their communities) as well as to promote the distribution of these critical supplies more generally. In the last year alone, dental health champion volunteers distributed 12,000 dental kits across almost all regions of Oregon. Not only did dental health champion volunteers lead most of these efforts, but some of those volunteers covered part or all of the cost of supplies. Dental kit projects have also led to broader efforts than expected, such as a countywide educational effort spearheaded by an OCF donor. OCF staff also occasionally hear about others assembling or distributing dental kits after learning about the projects through local events or meetings.

In addition to the efforts led by dental health champions, a few recent collaborations resulted in greater distribution of dental kits in conjunction with events. For the second year in a row, OCF donors and staff assembled and distributed kits at the Rosemary Anderson High School “We Got Your Back” event (providing school supplies to students in east Multnomah County). OCF staff also worked with an organization in Hermiston to make kits available for a local health fair earlier this year through the OCF Latino Partnership Program.



OCF staff and volunteers distribute dental kits at “We Got Your Back”

## EDUCATION AND ENGAGEMENT continued

### **5 The general public still needs greater awareness and understanding of dental health issues.**

School-based prevention program grantees and other stakeholders continue to express frustration at the general lack of awareness among Oregonians of dental health challenges and the importance of preventive care. Grantees must regularly make the case for their work with school administrators, staff and parents. While some have materials that explain the value of their work, most would like additional resources or to improve materials they currently use. Grantees also see a need for much broader awareness building and education efforts so that all Oregonians understand the importance of good oral health.

In summer 2015, OCF became an official ally of the American Academy of Pediatrics Campaign for Dental Health. As a result, OCF's logo now appears on the Academy's website, and OCF may use the Academy's communication tools. OCF staff disseminate any pertinent information to grantees (e.g., announcements about webinars) and direct volunteers to the site for resources, particularly regarding local water fluoridation efforts.

### **6 A pilot effort with parenting education programs is providing an emerging example of dental health integration.**

The Strategic Plan for Oral Health in Oregon: 2014-2020 calls for the integration of oral health education into general health education (including parent education) and for the development of culturally appropriate prevention messaging. Despite a desire to do so, OCF staff found it challenging to determine how best to go about integrating oral health in other OCF Initiatives — particularly parenting education. A national search turned up resources that were outdated, not inclusive and not behaviorally based, illuminating this challenge.

However, a focused effort is now underway to determine how best to include dental health education among participants in the Oregon Parenting Education Collaborative (OPEC) programs (and potentially similar parenting education programs) and to develop and refine such programming. Annette Leong, an OCF contractor, recently drafted an initial curriculum and piloted it with a small group of OPEC hubs. Participating hub leaders and parenting educators reported that fidelity to the original parenting education curriculum could still be achieved within the allotted class time with the addition of the oral health curriculum. The pilot effort also illuminated the need for this education among parents attending OPEC programs.

Additionally, as the pilot effort began, the contractor also started work with researchers at Oregon Research Institute and Oregon Research Behavioral Intervention Strategies to develop a National Institutes of Health (NIH) Small Business Innovation Research grant proposal. If awarded, the NIH funding would support the development and evaluation of a substantive multimedia intervention promoting children's dental health. This would provide resources for oral health education that do not currently exist and would be of great value nationally (potentially replacing existing resources provided by the American Dental Association). If NIH funding is not secured, OCF will continue to support oral health education in partnership with existing parenting programs, and has support from the OPEC funding partners to do so.

## OPPORTUNITIES for EDUCATION AND ENGAGEMENT

Based on our work to date, the evaluation team offers the following considerations for education and engagement efforts going forward.

**1 Maintaining and strengthening existing partnerships will require ongoing work.**  
OCF staff may need to more strategically consider which Initiative activities require active partner involvement and which do not. In addition, OCF will need to determine more generally how best to engage partners given turnover of key staff at funding partner organizations, and given those organizations' evolving priorities.

**2 Engaging dental health champions more intensively could be very effective, but would likely require significant staff time.**  
It is challenging for staff to dedicate the time needed to engage dental health champions more deeply. However, these volunteers are a valuable resource. It is possible that a more systematic effort to keep them apprised of the Initiative's progress and/or solicit their support via local educational efforts (e.g., speaking to school parent groups, Rotary clubs) would help advance the goals of the Initiative.

**3 Sharing what we are learning about the work of school-based prevention programs may be helpful to a range of oral health stakeholders; efforts to do so can increase going forward.**  
Through the Initiative, we are amassing a great deal of knowledge about how school-based prevention programs work, about the students they serve (e.g., risk of disease) and about the challenges they face in trying to support improved oral health in an ever-changing system of care. This information may be helpful not only to other prevention programs (non-grantees) and to OHA, but also to Dental Care Organizations (DCOs), Coordinated Care Organizations (CCOs), and other oral health stakeholders. To date, OCF has presented about the Initiative to a number of important groups, including CCO Dental Care liaisons and the Oregon Health Policy Board. As more detail becomes available about the accomplishments and challenges of the school-based prevention programs funded through the Initiative, there will be more opportunity to broaden awareness.

**4 Children's dental health month and the upcoming legislative session present an opportunity for increased education and engagement efforts.**  
National Children's Dental Health Month is February each year, and provides a good opportunity for either grassroots (e.g., donor, grantee or volunteer driven) or broader educational efforts. The Initiative should take advantage of any national or regional campaigns, using this as an opportunity to deepen engagement with dental health champions. In addition, the next state legislative session will also begin in February 2017. This will be an especially important window in which to share messaging about the value of oral health, oral health integration and the challenges related to accessing oral health care in Oregon.



White Bird

## FUNDING FOR PREVENTION SERVICES IN COMMUNITIES

### INITIATIVE AND EVALUATION PROGRESS

In the past year, much of the Initiative and evaluation efforts focused on the implementation of school-based prevention programming. School-based prevention program grantees have completed quarterly reporting about their services and participated in both a survey and interviews with the evaluation team. Grantees reviewed and discussed mid-school-year findings during a spring convening. Discussion there resulted in improved data submissions and a better understanding of the nuances of programming and data.

In addition, First Tooth programming funded through the Initiative wrapped up in 2015; a brief summary of those efforts are included in this report.

#### *Evaluation Question #2*

*How and how well are community-based prevention programs able to demonstrate how oral health care can be provided in an expanded health-care system?*

### FINDINGS

#### **1 The Oregon Oral Health Coalition successfully expanded the availability of First Tooth trainers.**

In October 2014, OCF awarded a grant to the Oregon Oral Health Coalition to expand the number of certified First Tooth trainers in the state. First Tooth trainers teach health-care providers (e.g., pediatricians) how to include oral health services for infants and toddlers in their practice. First Tooth staff held several Train-the-Trainer seminars for dental professionals in 2015, exceeding their goal to add 10 new certified trainers in five CCO regions. As of fall 2015, staff reported that a total of 23 new trainers completed the certification process. While conducting these trainings, First Tooth also worked with both Kaiser Permanente and Providence Health and Services to train additional trainers within their respective systems. These health-system-specific expansions were an unanticipated complement to First Tooth's Train-the-Trainer effort.

## FUNDING FOR PREVENTION SERVICES continued

### 2 In 2015-2016, eight school-based programs funded through the Initiative successfully expanded services and seven began to implement new programming.

This section of the report summarizes the efforts of the expansion grantees (those expanding existing services) and new program grantees (those developing and implementing new services) during their first full academic year of funding (2015-2016). It also includes a summary of their successes and challenges to date. Unless otherwise noted, the findings included in this section apply to both the expansion and new program grantees.

#### Consents

Consent processes vary across the grantees, and are often driven by school requirements. Some grantees are managing multiple types of consent forms for various schools. There are two main types of consent processes in use: 1) opt-in for everything — students cannot be screened or receive any treatment unless a signed consent is returned; and 2) opt-out for screening — no express consent is needed for screening, though parents are notified that screening will occur and are allowed to opt out.

Several expansion grantees are still working to improve the consent processes they use. Expansion grantees have tried several approaches to improve consent return this year, including sending forms home with students strategically (e.g., in homework folders) and providing classroom incentives like a pizza party or music day for classrooms with the most consent forms returned.

#### Screenings and Services

The expansion grantees have each implemented comprehensive programming slightly differently. Most commonly, screenings are provided during a screening day (or days) at each school, followed by a return trip on a later date for services such as sealants for those students in need of those services. The figures throughout this section summarize the work of seven expansion grantees that provided data about their work with first, second, sixth and seventh graders during the 2015-2016 school year.

- **Screening:** In the 158 schools served by the expansion grantees during the 2015-2016 school year, a total of 13,366 screenings were conducted, roughly 40 percent of possible screenings.<sup>1</sup> Twenty-three percent of screenings found untreated decay, a very similar proportion to that seen in the most recent Oregon Smile Survey, which found that 20 percent of children in Oregon 6-9 years of age had untreated decay.<sup>2</sup>

#### Grantees are screening more elementary students than middle school students.

Percentage of screenings conducted of those possible



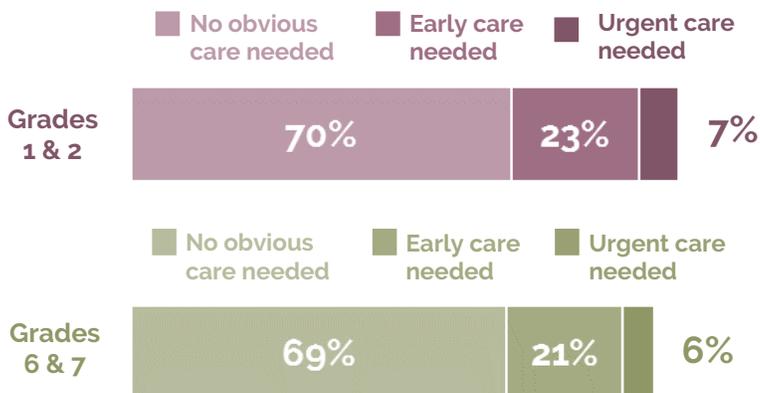
<sup>1</sup> Some students may be screened more than once per year, but we are not able to account for possible duplications of students. Possible screenings were calculated by multiplying the number of students enrolled by the number of screenings conducted. (e.g., if 70 students were enrolled in particular school and that school was screened twice, there were 140 possible screenings at that school).

<sup>2</sup> Oregon Health Authority (May 2012). Oregon Smile Survey. Note: The grantees and the Smile Survey use different screening protocols. OHA advises against direct comparisons of decay figures.

## FUNDING FOR PREVENTION SERVICES continued

### The need for care is fairly consistent across age groups.

Percentage of screening results by need for care



### A greater proportion of middle school students received sealants.

Percentage of screenings that resulted in sealant provision



- Education:** Expansion grantees provided education to more than 19,000 students during the 2015-2016 school year. Some expansion grantees provide education on a child-by-child basis (or in very small groups) at the time services (e.g., sealants) are provided. Several grantees have purchased Mercy Foundation's educational programming (Learning Lab) and are implementing that system during either screening or service days with larger groups of students. All grantees provide supplies for students (toothbrushes, etc.) who are either screened or served. Most also send paperwork home for parents that includes tips and general oral health information.
- Sealants:** The grantees documented the provision of sealants to a total of 3,824 students during the 2015-2016 school year — 2,433 students in first and second grade and 1,391 students in sixth and seventh grade. Because many more screenings were done in elementary grades, a greater proportion of middle school screenings than elementary school screenings resulted in sealants. Grantees noted several surprises with regard to sealant placement — the need for sealants was greater than expected generally, though some middle school students were not yet ready for sealants on their molars while other students had already received sealants by the time the program returned to place them.
- Fluoride varnish:** Most grantees would like to apply fluoride varnish, but due to concerns about parental confusion, lack of community support, conflicting viewpoints about fluoride efficacy and insurance restrictions, many have ceased providing fluoride varnish. However, grantees reported a total of 3,951 fluoride varnish applications during the 2015-2016 school year.

## FUNDING FOR PREVENTION SERVICES continued

- ***Follow-up for urgent care:*** Though 8 percent of screenings resulted in referral for urgent treatment (approximately 1,100 students), grantees could only confirm that 2 percent of students received follow-up treatment by a dentist. While several expansion grantees are able to conduct specific follow-up with students identified as needing additional care, many rely on school or clinic staff to do follow-up work, or expect parents to follow up with them based on the “report cards” sent home with students. Some grantees report that they are not able to follow up because school or clinic staff will not provide information about whether students sought or received services (usually due to HIPAA and/or FERPA concerns).

### Coordination and Relationship Development

Establishing relationships with schools is one of the most important roles of school-based prevention program coordinators. In addition to building relationships with schools, grantees are coordinating with dentists, dental hygienists and dental students to provide services. Grantees are also developing relationships with Dental Care Organizations (DCOs), Coordinated Care Organizations (CCOs), steering committees, volunteers and other community partners.

- ***Grantee relationships with both DCOs and CCOs are deepening, though there is room for growth, especially with regard to covering the costs of services.***

During telephone interviews with the expansion grantees in winter 2016, we learned that many were focusing their relationship-building efforts with the DCOs in their communities, relying on the DCOs to in turn work with their CCOs. At the time, almost all grantees reported positive relationships with the DCOs and CCOs with which they were already working, despite some challenges with regard to particular issues (e.g., some struggled to start relationships with particular DCOs or CCOs).

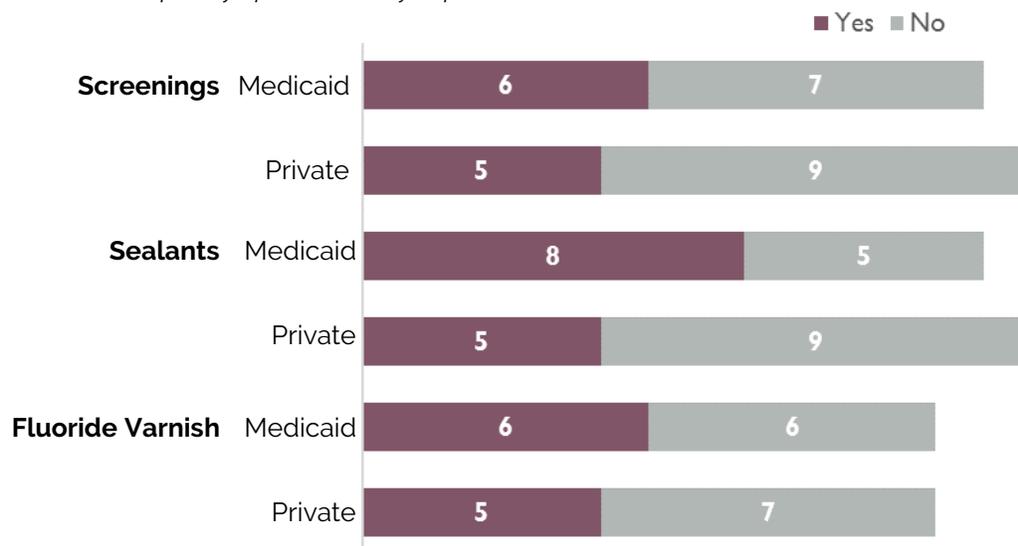
In a survey conducted in summer 2016, a majority of grantees reported that their level of interaction with both their DCOs and CCOs has deepened in the past two years (since prior to the start of health-care transformation). Almost half developed new relationships with DCOs or CCOs with which they had not previously interacted. This growth in interaction is not entirely attributable to the Initiative, though a few grantees report that their involvement in the Initiative has influenced their relationships. One stated that “the grant itself has made us look at our efforts as a part of a more comprehensive system.” It is important to note that despite this growth in interaction, a majority of grantees also reported that they would ideally interact more with their DCOs or CCOs than they are currently. A few noted that they continue to struggle to make inroads with particular DCOs or CCOs.

One of the best indicators of partnership between school-based prevention programs and DCOs, and an ultimate goal of the Initiative, is that DCOs cover at least some of the costs of these programs. In some cases DCOs are providing dental hygienists or other staff support for screenings and services, but most support from DCOs comes to programs as they bill for services, particularly for children on Medicaid. About half of the grantees reported that they are able to bill for screenings, sealants and fluoride varnish for children on Medicaid, and slightly fewer are also able to bill private insurance. Others are working on ways to bill insurance for services provided.

## FUNDING FOR PREVENTION SERVICES continued

### Grantee ability to bill Medicaid or private insurance for prevention services varies; around half are able to bill Medicaid for most services.

Count of grantees responding *Yes* or *No* to survey question: *Are you able to bill Medicaid or private insurance for any of the services you provide in schools?*



A few barriers to billing are clear from our interviews with grantees. There is some confusion about what DCOs can and should pay for (e.g., fluoride varnish or tablets, premolar sealants) and it is difficult for some grantees to report adequate data to DCOs for billing purposes. Some expansion grantees also expressed frustration with low rates of reimbursement.

- ***Expansion grantees have struggled to figure out how best to convene and use steering committees.***

The lack of use of steering committees by expansion grantees may be the result of their maturity as programs — these programs are up and running and may be well-integrated into the organizations that run them, and therefore governed by existing organizational structures (e.g., an organization's board). That said, grantees with active steering committees report that committees have provided guidance in navigating policy and practice issues (e.g., whether to participate in Advantage Dental's PREDICT project). Steering committees have also offered professional support and provided connections to schools, CCOs, DCOs and other community providers. As a result, grantees are developing local partnerships with other nonprofit organizations and outreach programs, government programs for children (e.g., Head Start), professional dental schools, and private dental practices.

- ***The use of volunteers varies by grantee; important volunteers include dentists and dental hygienists, as well as community members who serve on steering committees.***

The expansion and new program grantees have logged a total of over 5,600 volunteer hours to date. The total value of volunteer hours is almost \$120K (per values established by the Independent Sector in winter 2015). This is likely to be an undercount, as discussion at the spring 2016 grantee convening revealed that there was confusion about what types of volunteers should be included. In addition, the rate set by the Independent Sector doesn't adequately account for professionals like dentists who volunteer their time for some programs.

## FUNDING FOR PREVENTION SERVICES *continued*

- ***Grantees are learning important lessons about how best to build relationships with schools.***

In order to get permission to operate within schools, coordinators must work diligently to educate and build relationships with principals, school staff and community members. School staff are often overwhelmed and turnover is common, which means that patience is also necessary. Some schools (e.g., rural or Title I schools) also lack sufficient resources to support operations of the program. Program coordinators expressed concerns over functional electrical outlets, uncomfortably cold rooms and a general lack of sufficient space. Grantees also noted that working with middle schools and middle school students is very different from working with elementary schools and their students. Middle schools have different schedules, and students that age typically have more control over their participation, which means engaging them in services can be much more difficult. Some of the most important lessons grantees have learned to date about working with schools are:

1. Building relationships with the right people at each school is critical. This may vary by school but usually includes administrators, office staff and school nurses (where present).
2. Setting reasonable expectations for themselves and school staff is also important — for grantees, this includes not assuming that school staff will remember the process from the year prior.
3. Working proactively to avoid the busiest times of the school year is also beneficial for both the school and program staff.

### **Sealant Program Certification**

It has been challenging for grantees and OHA (not to mention the DCOs) to keep track of the various programs operating throughout the state. In some cases, this led to confusion about which programs were operating in which schools or districts, at least initially. OCF staff found they needed to be much more proactive than anticipated in communicating with grantees and OHA to support coordination of efforts.

As of this school year, SB 660 requires that school-based prevention programs like the Initiative grantees must be certified through OHA. A survey conducted in late summer 2016 revealed that eight of the current CDHI grantees had completed certification. Most others had at least partially completed the necessary training that precedes certification. However, there does seem to be continued confusion for some grantees about the specifics of certification requirements.

Certification requirements include training for program coordinators and those providing sealants, approval of the CCO operating in the community, entry of encounters into the Medicaid system, planning and implementation of parent permission systems, use of appropriate techniques for sealant provision, and provision of annual reports to OHA, including aggregated data for each school served (e.g., number of children screened, receiving sealants, and referred to early or urgent care). It will be revealing to see whether placing the burden of coordination and approval of programs on CCOs has an impact on the coordination challenges experienced to date, or if it raises more awareness of programs doing this work among CCOs.

# OPPORTUNITIES for FUNDING PREVENTION SERVICES

Based on our work to date, the evaluation team offers the following considerations for funding prevention services going forward.

## **1** There is room for improvement on several elements of grantee programming, including the consent process, fluoride treatments, education and follow-up for urgent care.

The grantees recognize that there are ongoing challenges to get parent permission for service provision, as discussed above. There is also considerable variation in the degree or manner that some grantees are including fluoride treatment and education efforts in their programming. That variation is “washed out” to some extent in the summary data. Finally, follow-up for urgent care is critical, but not easy for the grantees to do or to track, given data system issues and privacy concerns. In addition to fostering information sharing among the grantees that can help support improved practice, one more targeted approach might be to pair up funding partner staff with particular grantees around particular issues, so that each funding partner can provide or foster coaching on one or more particular challenges and/or work to raise awareness of the grantees’ challenges among stakeholders.

## **2** Ongoing education and coordination will help ensure successful statewide certification of school-based sealant programs.

OCF can combat continued confusion about the certification process and requirements by continuing to seek clarification with OHA as needed, and by helping OHA communicate with Initiative grantees and others.

## **3** Much work remains to improve tracking of services and oral health outcomes.

Some school-based prevention programs and their partner DCOs/CCOs have made great strides in capturing services at the individual level, allowing for services like sealants to be “encountered” in the Medicaid system. In a few cases, DCOs are providing staff (typically dental hygienists), both to support screening and service provision and to record services in DCO health information systems. However, many programs are still determining how best to accomplish this, given staff and data system capacity. Some program staff report that they are entering data twice — once into their own system to track the total number of students served and services rendered, regardless of insurance status, and once into their DCO’s system (for those covered by that DCO). In addition, OHA is still clarifying some of the annual reporting requirements for certified school-based sealant programs. Until this happens, we will not know whether the data required will be sufficient to summarize oral health services or outcomes across the state.

## **4** Clarity and consistency as well as improved data systems are needed in order to ensure grantees can bill Medicaid and private insurance for services.

OCF and its funding partners may need to either advocate with DCOs for clarity and consistency in what grantees can bill Medicaid and private insurance for, or help facilitate grantees and DCO arrangements for such billing. Data system improvements are also necessary for some grantees to be able to provide data needed for billing. Further exploration of barriers to billing may also help identify ways to ensure billing is possible.

# STATEWIDE LEADERSHIP AND ADVOCACY

## INITIATIVE AND EVALUATION PROGRESS

The first step in understanding how OCF efforts contribute to policy, funding and systems changes is to understand the current policy, funding and systems context and to track how that context evolves. This is reflective of the systems perspective we are employing for this evaluation. We are studying and will continue to actively study the complexity of the Initiative's strategies as well as the context in which the Initiative operates, and the barriers that exist within that context.

Initiative efforts to provide statewide leadership and advocacy commonly occur in partnership with the Oral Health Funders Collaborative of Oregon and SW Washington. Activities include support for development of the Strategic Plan for Oral Health in Oregon: 2014-2020 and advocacy for its ongoing implementation, as well as advocacy for the hiring of a Statewide Dental Director. The evaluation will continue to track OCF staff and partner efforts to lead and advocate for children's oral health in Oregon, including progress made on a more formal advocacy plan developed in fall 2016.

### *Evaluation Question #3*

*How do Initiative efforts contribute to policy, funding and systems changes?*

## FINDINGS

### **1 The system of care for children's oral health in Oregon is complex, multilayered and evolving.**

Health-care transformation is still underway in Oregon, and there is a wide range of organizations involved at various levels of the system of care for children's oral health in Oregon. We are beginning to map that system, which will help us communicate about the complexity of the system and to track changes in the system.

The policy context is also evolving. During the last legislative session, five bills passed through the Oregon House and Senate that resulted in changes to the system of support for children's oral health in Oregon, including SB 660, which mandates certification for school-based sealant programs, and SB 2972, which requires public schools to report whether incoming students aged 7 or younger had a dental screening prior to school.

### **2 Partnership with the Oregon Health Authority (OHA) is deepening and continues to be critical to all aspects of the Initiative.**

As the state agency that supervises health care transformation and the integration of oral health in that system, OHA is a critical partner in OCF's efforts to improve the system of supports for children's oral health in Oregon. OCF continues to strengthen its relationship with key staff at OHA, helping to raise awareness of the importance of children's dental health within the state agency. The strengthening relationship between OCF and OHA has been especially evident through recent communications about the upcoming 2017 Oregon Smile and Healthy Growth Survey and the certification of school-based sealant programs as mandated by SB 660. OHA staff have reached out to OCF staff to provide updates on planning and implementation of both efforts, and have been very receptive to questions and suggestions.

## STATEWIDE LEADERSHIP AND ADVOCACY continued

Over the past few years, OCF (along with other stakeholders) encouraged OHA to expand the size and scope of the Smile Survey to improve the significance and granularity of the data. OHA staff responded by developing a plan for the 2017 Smile Survey to collect data from a seven-region sample instead of a six-region sample. This marks a significantly increased undertaking by OHA, requiring sampling of an additional 55 schools beyond the 82 schools sampled for the 2012 Smile Survey. In response to OCF staff offers to support Smile Survey planning and implementation, OHA approached OCF with a concrete request for support in spring 2016. In summer 2016, the board approved funding for assistants to support the dental hygienists who conduct the screenings for the Oregon Smile and Healthy Growth Survey. In addition, OCF provided \$12K in dental kit supplies for students screened as part of the Survey.

OHA had a strong presence at the spring 2016 convening of Initiative grantees. OHA Director Lynne Saxton provided a keynote updating attendees on the work of OHA and underscoring the value of the work of school-based oral health programs. Dr. Bruce Austin, the Statewide Dental Director, also spoke, and staff from the Oral Health Unit also presented and answered questions about the new school-based sealant program certification and the upcoming Smile Survey.

### **3 OCF staff and leaders are increasingly included in important conversations, and have presented information about the CDHI and the importance of oral health care in a number of venues.**

The following are highlights of these important leadership opportunities:

- In November 2015, Melissa Freeman and Dr. Bruce Austin (Statewide Dental Director) were invited to speak at the Oregon Health Policy Board, giving the first presentation on oral health that the board had received. They reinforced the importance of oral health-care and its integration into the broader health care system, and updated the board on the Initiative and OHA's efforts related to oral health. The board expressed interest in the topic; OCF should watch for future opportunities to keep the board apprised of what we are learning through the Initiative.
- Melissa Freeman served as a panelist at the Healthiest State event last fall, presented at the Coordinated Care Organization Summit in Portland as part of a panel on oral health integration, and organized and facilitated a panel session on oral health for the Grantmakers of Oregon and Southwest Washington conference this spring.
- Melissa and Molly Yeend made valuable connections with key staff from the CCOs at a meeting of CCO dental liaisons in spring 2016. Several then attended the grantee convening in May to network with school-based programs and learn more about the Initiative, some serving on a panel of CCO and DCO representatives who shared their work with the grantees as well.
- In addition, OCF staff met with OHA staff periodically throughout the past year, discussing the Oregon Smile and Healthy Growth Survey, the certification process for sealant programs, and related issues. OHA approached OCF as one of several key stakeholders for an update prior to finalizing its plan for the 2017 Smile Survey.

## STATEWIDE LEADERSHIP AND ADVOCACY continued

### 4 Ongoing involvement with statewide organizations such as the Oregon Oral Health Coalition (OrOHC) continues to be important for systems and policy work.

As mentioned previously, OCF staff and leaders continue to be actively engaged with the Oral Health Funders Collaborative, the OrOHC) and OHA. Much of OCF's advocacy work happens in partnership with the Oral Health Funders Collaborative and many projects happen in partnership with the other two organizations (e.g., strategic plan). Maintaining OCF's engagement with these organizations is necessary to continue to provide leadership in the funding community and more broadly around this issue.

### 5 The Strategic Plan for Oral Health in Oregon: 2014-2020 remains an important guiding document, though other strategic planning efforts are now underway at OHA and regionally.

A Progress Report on the Strategic Plan will be completed for the OrOHC's annual conference in November 2016. That report will assess progress on the various components of the plan and highlight the strides various communities and organizations are making to improve conditions for oral health.

In response to the Strategic Plan's launch in 2014, OHA is currently developing an internal strategic plan for oral health. We expect that OHA will align that plan with the relevant recommendations in the Strategic Plan for Oral Health in Oregon: 2014-2020. In addition, CCOs and local health coalitions are completing their own strategic plans (including Community Health Improvement Plans).



## STATEWIDE LEADERSHIP AND ADVOCACY continued

### 6

OCF has begun developing a strong advocacy plan, focused on 1) improving and expanding the state's oral health data surveillance system, 2) integrating school-based programs into Oregon's health-care system and 3) increasing access to fluoridated water for all Oregonians.

#### **Oral health data surveillance system**

The Association of State and Territorial Dental Directors (ASTDD) produced a guide for best practices for state-based oral health surveillance systems in 2011. At face value, the Oregon system seems to have many of the qualities outlined in the guide. However, a more robust assessment of the system could shed light on specific ways that the system could include data that is currently missing, improve the quality of existing data or make it available in a more useful or timely manner. The ASTDD report includes recommendations and resources for evaluating state systems, as well as examples of state systems that are likely to be highly useful as stakeholders explore next steps for system improvement.

Of course, any consideration of improvements to the current oral health data surveillance system must start with discussion with OHA leaders and staff to assess current strengths and weaknesses and to identify potential improvements. Fortunately, recent conversations with OHA Oral Health Program staff indicate there is great interest and willingness to improve the current system (and that clear ideas about how to do so exist).

#### **Integrating school-based programs into Oregon's health-care system**

Statewide certification is an important step in coordinating and ensuring programs meet minimum quality requirements. Because the Initiative is engaging so many school-based prevention programs throughout the state, there is great opportunity for OCF and funding partners to support stronger collaboration among OHA, local providers and DCOs/CCOs in order to integrate these programs more effectively into the broader system of care. It is clear from our conversations with grantees that some will need continued or additional guidance and support, especially in developing relationships with DCOs and CCOs (and potentially even mediation where existing relationships are strained). OCF and its funding partners are well-positioned to help school-based prevention programs navigate the ever-changing landscape.

#### **Increasing access to fluoridated water for all Oregonians**

Water system fluoridation remains one of the most powerful ways to combat oral health challenges but remains controversial in many communities in Oregon. Research strongly supports the safety and effectiveness of water fluoridation to protect teeth from decay. However, water fluoridation challenges continue to surface. Most recently, the City of Newport voted against reinstating fluoride in the community water system in May of 2016. In addition, a public employee in Coquille discontinued fluoridation without informing the mayor's office or the medical/dental community; this was unknown to all until the Oregon Drinking Water Services (DWS) completed annual testing of the system. Fortunately, in the case of Coquille, advocates (including the Statewide Dental Director, retired dentist Dr. Kurt Ferré and local dentists) jumped into action, clearing up misconceptions about the safety of fluoride. As a result, the community reinstated fluoridation within just a couple of weeks.

## STATEWIDE LEADERSHIP AND ADVOCACY continued

### **7 CCOs are already showing improvement on the dental sealant metric, a good indication that data capture and/or sealant provision is already improving.**

A [June 2016 performance report](#) from OHA shows marked improvement on the sealant metric regardless of race and ethnicity or age group. Overall, billing claims show that 18.5 percent of children received sealants in 2015, up from just over 11 percent in 2014, but not quite hitting the 20 percent benchmark set for 2015. Children ages six to nine fared slightly better than those aged 10 to 14. Almost 21 percent of children aged 6 to 9 had a sealant (meeting the 20 percent benchmark), whereas almost 17 percent of those 10 to 14 had a sealant. OHA reported that 4 CCOs met the benchmark, while all 12 others met improvement requirements (improving between approximately 6 and 13 percent each).

As of yet, only a few of the Initiative expansion grantees are providing child-specific information to their DCOs, though many (if not all) of the new program grantees are planning to do so. Advantage Dental is by far the most prepared to work with prevention programs to capture this data — they have built a section of their health information system for this purpose and have provided dental hygienists to conduct screenings and sealants for some programs in order to ensure services are performed and data is captured. Many challenges regarding this remain. Programs in the catchment area of several DCOs must potentially work with several health information systems, and some programs and DCOs simply do not have the capacity to capture and manage child-level health information.

### **8 OCF and its funding partners proactively voiced concerns about Advantage Dental's PREDICT project and helped school-based programs and other stakeholders understand the nature and implications of the project.**

In late 2015, Advantage Dental announced a new project to work on implementation of silver diamine fluoride treatments in school-based prevention program settings. In partnership with University of Washington researchers, they selected a group of treatment and control counties, and planned to roll out the effort in early 2016. After many conversations with both Advantage Dental staff and school-based prevention program stakeholders, OCF sent a letter to grantees on behalf of the Initiative funding partners indicating that the funders were not endorsing the project, but instead would leave decisions about whether to participate up to the programs and communities Advantage Dental wished to include. Grantees were reassured that their participation (or lack thereof) would not impact their funding, and heard reminders of programming expectations for the Initiative grant. Some have chosen to participate while others have declined. OCF's cautious approach to handling this may have taken time, but is sure to have helped stakeholders understand what the project does and doesn't entail and its potential local implications for school-based prevention programs. OCF also actively encouraged Advantage Dental to improve its own communications about the project (e.g., by adding photos to consent forms), so that parents would have appropriate expectations about the treatment (silver diamine fluoride) used in the project.

# OPPORTUNITIES for STATEWIDE LEADERSHIP AND ADVOCACY

Based on our work to date, the evaluation team offers the following considerations for statewide leadership and advocacy efforts going forward.

## 1 **OCF should continue to foster relationship-building with OHA.**

OHA holds a great deal of power with regard to how the system for dental health works in Oregon and continues to undergo change as efforts are organized. Ongoing strategic planning efforts within OHA provide an opportunity for OCF to further support and hold OHA accountable for improving the system of support for children's oral health. More regular or frequent meetings with funding partners and/or OHA, perhaps focused on inviting one another to present updates on the various efforts underway, could help keep all parties informed and support further relationship development.

## 2 **OCF could facilitate learning about the oral health surveillance system for members of the Oral Health Funders Collaborative.**

The Oral Health Funders Collaborative was not interested in funding OHA's request for support regarding the 2017 Oregon Smile and Healthy Growth Survey, but is very interested in exploring potential improvements for the oral health surveillance system more broadly. The Collaborative would likely benefit from an overview of the surveillance system by OHA Oral Health Program staff. OHA Oral Health Program staff also have many ideas about potential improvements; discussion could help the Collaborative identify specific ways to support or advocate for system improvements.

## 3 **While regional strategic planning is underway and already complete in some communities, there may still be opportunities to advocate for the inclusion of oral health as a priority in CCO and local Community Health Improvement plans.**

This is already a component of OCF's advocacy plan for the next several years of the Initiative. To support this effort, the OCF evaluation team plans to review all available community and CCO plans over the coming year in order to identify opportunities for the Initiative to leverage these plans for local communities.

## 4 **The upcoming legislative session provides opportunities to apply recommendations from the Strategic Plan for Oral Health in Oregon: 2014-2020.**

The Strategic Plan outlines strategies that overlap with those noted in this and previous reports. Issues such as the lack of services in rural areas are challenges that policy, funding and systems changes could address. OCF staff are currently planning for advocacy efforts during the upcoming legislative session. For example, there may be unfinished work to do regarding bills from the previous legislative session, such as SB 2972, which was intended to require that all students receive oral health screenings prior to entering elementary school. As mentioned above, the State Board of Education completed rulemaking over the summer, softening the requirements significantly in comparison to what oral health stakeholders had hoped to see. During the rulemaking process, OCF submitted public comment on behalf of the Oral Health Funders Collaborative, advocating that the State Board of Education include screening results in reporting requirements. Since then, conversations with local lawmakers indicate there may be enthusiasm for strengthening this in the upcoming legislative session.

## OPPORTUNITIES for STATEWIDE LEADERSHIP AND ADVOCACY

### 5 In order to encourage the success of the 2017 Oregon Smile and Healthy Growth Survey, OCF and partners can encourage schools and programs to participate.

While implementation of the 2017 Oregon Smile and Healthy Growth Survey is now underway, a few communication and engagement needs will be ongoing throughout the school year. First, sampling and engagement with schools will happen throughout the school year, as will scheduling of screening visits themselves. Second, OHA anticipates that the need to recruit dental hygienists and assistants to conduct the Smile Survey itself (a screening process) will also be ongoing (OHA anticipates shortages in hygienists willing to participate). OCF and its partners could support OHA by communicating proactively with school-based prevention programs about the Smile Survey. OCF and its partners can encourage programs to support the schools they work with, if sampled (e.g., by encouraging them to agree to participate and adjusting scheduling as needed), and can also ask school-based prevention programs to support the dental hygienists and other staff with whom they work so that they can participate in Smile Survey efforts. OCF and its funding partners may also want to explore ways to encourage school administrators more directly (perhaps through the Oregon Department of Education).

