The Oral Health of California's Children: Halting A Neglected Epidemic

Selected Recommendations from the Children's Dental Health Initiative Advisory Committee

The Dental Health Foundation - 2000
In 1993-94, the first ever statewide oral health needs assessment (The Neglected Epidemic) revealed that California’s children are experiencing an epidemic of oral disease. California’s children have twice as much dental disease as the national average. In response to these startling findings, a broadly representative partnership of experts from throughout California was convened to develop the recommendations contained in this action plan.

With support provided by The California Endowment, the Dental Health Foundation was able to convene the Children’s Dental Health Initiative Advisory Committee comprised of dedicated individuals representing the health professions, children’s advocacy organizations, philanthropies, government agencies, the dental insurance industry, academia, and community-based organizations. Over the course of two years, the Advisory Committee has worked to understand the causes of children’s oral health problems, identify feasible solutions, and translate causes and solutions into a plan for action.

Now we must make a new commitment to the children of California. This Plan provides the large-scale road map to action. Like any map, the intent is to use this Plan as a guide. Throughout California, individuals and organizations who are dedicated to the health of our children now have the opportunity to design and implement programs, influence policies, affect the allocation of resources, and attempt to promote healthy personal behaviors that improve oral health. This is where the journey really begins.

The Children’s Dental Health Initiative Advisory Committee is providing the fuel for the engine that will drive change for the children of California over the coming decade. Please feel free to share this Plan with others.

The more people who read the Plan and understand the need for commitment to our children, the greater chance we have to improve oral health. It is time to reverse years of lagging behind the rest of the country. We have defined the magnitude of the problem. We have designed solutions. Now, each of us must develop the political will to strategically bring these solutions to fruition. We encourage your committed action to assure a healthy future for California’s children.

Arlene Glube, BS, RDH, Chairperson
The Dental Health Foundation

Jared I. Fine, DDS, MPH, Chairperson
Children’s Dental Health Initiative Advisory Committee
CHILDREN’S RIGHTS TO ORAL HEALTH CARE

• Every child has a right to a dental home: a place to receive care that is family-centered, comprehensive, and culturally appropriate.

QUALITY OF CARE

• Oral health services should be of high quality and reflect best practices.
• Meeting some oral needs of many individuals should take precedence over meeting most needs of a few.
• Oral health is an integral component of overall health.

PREVENTION AND EDUCATION

• Prevention should take precedence over cure, but needs for urgent care cannot be ignored.
• A portion of every dollar spent on oral health services should be spent on prevention.
• Oral health education should be a required part of school health education.

PARTICIPATION OF ALL STAKEHOLDERS IN FOSTERING CHILDREN’S ORAL HEALTH

• Local communities must be responsible for local solutions.
• Publicly funded oral health care is needed to fill gaps between oral health needs and existing private resources.
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California’s children are plagued with oral diseases that cause them pain, distract them from play and school, disfigure their smiles, and make it hard to eat.

Many other childhood diseases—for example, measles, mumps, and whooping cough—are well managed, or have been nearly eliminated by aggressive prevention programs. But oral diseases remain unchecked. In fact, they are the most prevalent and the most untreated childhood diseases in the country.¹ No wonder one in ten Americans over age 18 no longer have any of their natural teeth.²

Oral diseases are not minor annoyances—just a cavity that can be filled or a tooth that can be extracted. For many children, tooth decay severely interferes with eating, sleeping, speaking, learning, and playing.

Oral diseases are also very costly. A study of data from the 1989 National Health Interview Survey found that children missed more than eight million school days because of dental problems. Low-income children are especially vulnerable: They miss nearly twelve times as many school days because of dental problems as higher-income children.³
Over the past decades, the oral health of the nation’s children has improved. But in California, often the pacesetter and innovator in public health efforts, the trend has gone the opposite direction.

- California’s children have twice as much untreated decay as their national counterparts.
- Only 10 percent of California 8-year-olds get sealants for their first permanent molars.
- One-third of the parents of California preschoolers report giving them nighttime bottles, a practice that promotes tooth decay.
- Only 30 percent of Californians currently receive the benefits of fluoridated water.

California’s children are walking dental disasters.
Nearly half of California’s Asian and African American high school students and three-quarters of Latino students need dental care.

More than 25 percent of California’s preschool and elementary school children and more than 40 percent of high school students have no dental insurance.

More than half of 10th graders are in need of dental care.

ORAL DISEASE IN CALIFORNIA HAS REACHED EPIDEMIC PROPORTIONS
Access to oral health services is poor for all California children, but it is even worse for children of color.

About 40 percent of preschoolers and approximately 65 percent of elementary school children of color need dental care (includes urgent and non-urgent needs). Many high school students of color also need care. Nearly half of Asian and African American students and three-quarters of Latino students need dental care.

Oral diseases are almost entirely preventable, and routine care can detect and correct problems before they become serious. But more than 25 percent of California’s preschool and elementary school children and more than 40 percent of high school students have no dental insurance. Even 40 percent of children who have medical insurance have no dental insurance.

Families who lack dental insurance are less likely to get routine care and often encounter other barriers to care that trap them in a cycle of chronic oral diseases.
These sobering facts about the state of our children’s oral health come from California’s first comprehensive assessment of children’s oral health. Conducted in 1993-1994, the California Oral Health Needs Assessment of Children was the first step in our strategic campaign to control this destructive and costly epidemic. Selected findings from the assessment were published by The Dental Health Foundation in 1997 in its landmark report, *The Oral Health of California’s Children: A Neglected Epidemic*.

The California Endowment helped us take the next steps by funding the Children’s Dental Health Initiative (CDHI), a broad-based partnership of health professionals, advocacy groups, philanthropic organizations, government agencies, and representatives from the dental insurance industry and from community organizations. Together, the CDHI Advisory Committee and project staff examined the causes of the epidemic, identified feasible solutions, and translated causes and solutions into a strategic plan for action.

It should be noted that not every member of the Advisory Committee endorsed every recommendation contained in this report. However, the recommendations do represent the consensus of an exceptionally diverse panel, and unanimous support exists for a great many of the recommendations.
The California Oral Health Needs Assessment focused attention on the dangerous state of our children’s oral health. We’ve taken the next steps—identified recommendations for halting the oral disease epidemic and developed plans for action. Making change happen will require the coordinated efforts of all those who care about the health of California’s children.
A CALL TO ACTION

Now it is time for action—time to implement an action plan before the oral health of our children declines further. But winning the fight against this hidden epidemic will require more than a sound plan. It will require an integrated campaign.

- We need medical and dental organizations, local health departments, school districts, and community and advocacy groups to educate parents, physicians, dentists, and school personnel about the urgency of detecting and treating dental disease. For example: We should train healthcare professionals and community outreach workers to identify dental problems early and refer children for care. We need to increase training available to dentists, hygienists, and dental assistants about how to manage and treat very young children.

- We need legislators, philanthropic organizations, and state agencies concerned with health issues to expand access to oral health services and to focus other efforts to increase care cost-effectively. For example: Whenever appropriate, publicly funded health programs should have a dental health component. Schools and county child welfare workers should promote the dental services available to children through Medi-Cal and the Healthy Families program.

- We need universities and research institutions to conduct evaluation studies so that we will know which of our efforts are most cost-effective. For example: We should use the same methods and criteria to evaluate oral health programs as those used to evaluate other children’s health issues. We should develop a statewide research program to study the cost of preventing versus treating oral health diseases associated with using all forms of tobacco.
The recommendations that follow outline a plan for halting California’s epidemic of oral disease. We urge the State of California, all those who participate in delivering dental care, and all those concerned about the health of California’s children to pursue five broad goals:

1. **EXPAND ACCESS TO COMMUNITY WATER FLUORIDATION**

2. **IMPROVE ACCESS TO DENTAL CARE**

3. **EXPAND SCHOOL- AND COMMUNITY-BASED DENTAL PROGRAMS**

4. **EXPAND EFFORTS TO PREVENT TOOTH DECAY IN VERY YOUNG CHILDREN**

5. **INVOLVE THE DENTAL PROFESSION IN PROGRAMS TO PREVENT CHILDREN’S USE OF TOBACCO**

Like any strategic campaign, this one requires sustained commitment. Some actions to improve the oral health of California’s children can take place now. Others will happen over the next 2-5 years.

But we must begin today. The cost of delay—in terms of human suffering and wasted potential—is too high. California should lead the nation in efforts to improve children’s oral health just as it leads in so many other areas. We urge you to join us in taking the next steps.
EXPAND ACCESS TO COMMUNITY WATER FLUORIDATION

Flouridation is widely accepted as the single most cost-effective measure a community can undertake to improve the oral health of its residents. The Oral Health Needs Assessment found that children in non-flouridated areas had 36-54 percent more tooth decay than children in flouridated areas.

Flouridation is an ideal public health measure because it benefits the entire community, regardless of age, ethnicity, or socioeconomic status, and because no individual conscious action is needed (other than drinking water) in order to receive its benefits. But currently, only 30 percent of the state’s population receives the benefits of flouridated water.4

In 1995, the California Legislature passed Assembly Bill 733, requiring flouridation for all communities with water systems having at least 10,000 connections (about 25,000 people), once funding becomes available. The legislation did not allocate any funds, but it stimulated some communities to move ahead. For example, aided by a $15 million dollar grant from The California Endowment, major communities such as Sacramento and Los Angeles have flouridated their water supplies, and plans are under way in Mountain View, San Diego, and Modesto. However, without state funding and leadership, full implementation will probably take many years.

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<td>Develop programs to educate operators of local water treatment plants about the public health issues surrounding flouridation and the technologies required.</td>
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<td>Increase financial support for capital, operations, and maintenance costs of community water flouridation.</td>
<td>Year 1-2</td>
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<td>Expand provisions of the statewide flouridation act to wholesalers.</td>
<td>Year 1-2</td>
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<td>Develop media campaigns and community seminars to help residents in non-flouridated areas understand the value of flouridation.</td>
<td>Ongoing</td>
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**IMPROVE ACCESS TO DENTAL CARE**

Access is a shorthand term for people’s ability to obtain the health care they need. The Institute of Medicine defines it as “the timely use of personal health services to achieve the best possible health outcomes.” Lack of access is a problem when it systematically results in poor health outcomes for certain individuals or groups.

There are many potential barriers to dental care—for example, lack of dental insurance, the fact that higher-income and urban areas have more dentists per capita than lower-income and rural areas, language and cultural barriers, and problems associated with child care and transportation. In addition:

- **Few publicly supported programs address access to dental services.** The majority of federally and state-supported community and migrant health centers in California do not have a clinical dental component.

- **Few school-based/school-linked health centers include dental services,** and there are few state-supported, school-based / school-linked preventive dental programs.

- **Too few dentists are willing to provide care for low-income children.**

- **There are very few pediatric dentists in California.**

- **Children do not have direct access to dental services through California’s Children’s Treatment Program.** (This program is part of the state-funded Child Health and Disability Prevention Program, which provides health services to low-income children.) The Children’s Treatment Program will reimburse dental providers only if children are referred by a medical “gatekeeper” and have obvious dental problems. This restriction means that children cannot be referred for preventive dental care.

The many dimensions of the access problem require a multidimensional solution. The following recommendations provide a comprehensive approach.
### ACCESS: INCREASE PUBLIC AWARENESS OF ORAL HEALTH

We need to help decisionmakers and the public learn the importance of oral health. We need to provide information, presented in easily understandable formats, about oral health status, strategies for preventing oral disease, and links between oral health and general health.

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<td>Publicize the prevalence of oral diseases, the ease and low cost of preventing them, and their link to general health problems.</td>
<td>Now</td>
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<td>Develop programs to inform Medi-Cal and Healthy Families enrollees about their dental benefits and the importance of early and periodic dental visits to prevent oral disease.</td>
<td>Year 1-2</td>
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<td>Encourage county social service workers and those who help applicants to enroll in the Healthy Families program to promote the dental services available to children through Medi-Cal and Healthy Families.</td>
<td>Year 1-2</td>
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<td>Sponsor statewide, regional, and local conferences for healthcare providers, children’s advocates, and policymakers on improving access to dental care.</td>
<td>Year 1-2</td>
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<td>Encourage all dental insurance and dental managed care plans to provide coverage for dental sealants and other scientifically proven preventive measures.</td>
<td>Year 1-3</td>
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Communities often have the resources they need to improve their children’s oral health, but they use the resources inefficiently. In other cases, existing resources may be so restricted in their application that they cannot be fully utilized to reduce barriers to care. For example, the Healthy Families program gives eligible families access to subsidized health insurance. Some families that would otherwise be eligible for Healthy Families insurance have medical coverage, but no dental coverage, through an employer. Under existing regulations, these families cannot apply for dental-only coverage through Healthy Families.

Every child should have a dental home—a place to receive care that is family-centered, comprehensive, and culturally appropriate. A dental home implies joint accountability between the dentist and the family, and providing a dental home means addressing the dental and non-dental needs of both the child and the family. For the primary-care dentist, this may involve making referrals to community, state, and federally funded resources that will benefit child and family.

Proposition 10 (the California Children and Families First Initiative) and the tobacco settlement represent major new sources of revenue that could potentially fund children’s oral health programs. Because Proposition 10 focuses on early childhood development, and because tooth decay in very young children has been linked with many child development problems, programs to prevent early tooth decay are a reasonable expenditure of Proposition 10 funds. Similarly, because tobacco use is clearly linked to oral disease, using tobacco settlement funds to support oral health programs makes sense.

### HOW TO DO IT

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<tr>
<td>Investigate allowing eligible children to obtain dental-only coverage through the Healthy Families program.</td>
<td>Year 1-2</td>
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<td>Launch a new state partnership: Expand the Children’s Dental Health Initiative Advisory Committee to become the California Oral Health Partnership, a collaborative of organizations and key individuals supporting oral health.</td>
<td>Year 1-2</td>
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<td>Train healthcare professionals and community outreach workers to identify dental problems early and refer children for care.</td>
<td>Year 1-2</td>
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<tr>
<td>Help school-based/school-linked health centers establish connections to ongoing dental care by establishing a system for referral and follow-up of dental problems.</td>
<td>Year 1-2</td>
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<td>Publicly funded dental programs should issue annual performance reports describing the kinds of services they provided to their enrollees.</td>
<td>Year 1-2</td>
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<td>Reimburse dental providers in publicly supported health programs such as Medi-Cal and Healthy Families at a level sufficient to cover costs of care and to attract new providers.</td>
<td>Year 1-2</td>
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<td>Expand the dental safety net that provides care to underserved children by increasing the number of school-based/school-linked health centers, community dental clinics, and dentists who serve these children.</td>
<td>Ongoing</td>
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<td>Use some of the funds available through Proposition 10 (the California Children and Families First Initiative) and the tobacco settlement to support children’s oral health promotion, disease prevention, and treatment programs.</td>
<td>Ongoing</td>
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Policymakers often do not view oral health as an integral part of overall health, perhaps because they do not understand the magnitude of oral health problems, the extent to which they can be prevented, and the link between dental and general health problems. Policymakers may also share the common view that dental services “cost too much.” In reality, the “high cost” of dental care merely reflects the epidemic nature of dental disease, and could potentially be offset by savings that result from increased investment in preventive dental care.

As a result, oral health is often forgotten in designing or developing primary healthcare service systems. An obvious example is use of the term “health insurance” to refer to medical insurance and the common failure to include dental coverage as part of “health” coverage. This is more than simply a matter of semantics: Policymakers and the public rarely think about dental coverage in discussions of health policy and health coverage.

States that have a full-time dental director in the state health agency are much more active in assessing oral health needs, developing supportive policies, and ensuring that the needs of underserved populations are met. Since 1994, California has not had a dentist responsible for dental health public programs in the Department of Health Services, and only a handful of local health departments have staff with dental public health expertise.

Recognizing that oral health services are an essential component of community health systems will help those services better meet community needs. It will also prevent isolating care of the mouth from care of the rest of the body.

## HOW TO DO IT

| Make sure that Medi-Cal managed-care contracts have formal arrangements with both medical and dental providers. | Year 1-2 |
| Create statewide standards for the Children’s Treatment Program within the Child Health and Disability Prevention Program so that all counties provide benefits with similar scope and frequency and use at least Denti-Cal levels of reimbursement. | Year 1-2 |
| Appoint a dentist with public health training and experience to direct the Office of Dental Health Services in the California Department of Health Services, and give the Dental Director significant authority over dental public health policies. | Year 1-2 |
| Whenever appropriate, publicly funded health programs should have an oral health component. | Year 1-3 |
| Encourage all local Maternal and Child Health programs funded by the Department of Health Services to conduct periodic and ongoing oral health needs assessments and to develop an oral health improvement plan within their scopes of work. | Ongoing |
| Use the same methods and criteria to evaluate oral health programs as those used for other children’s health issues. Criteria should include quality of life, disparities among populations, cost-effectiveness of preventive measures, and treatment costs. | Ongoing |
A recent national study found that the most important barrier to primary care was lack of health insurance coverage. This finding also applies to dental care: Children under 17 who have no health insurance are three times as likely as privately insured children to be unable to get dental care.5

Having dental insurance is one of the best predictors of whether an individual sees a dentist. More than one-quarter of all the children in the California Oral Health Needs Assessment had no form of dental insurance.

Care of the mouth should not be isolated from care of the rest of the body.

### ACCESS: REDUCE FINANCIAL BARRIERS TO CARE

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<td>Ensure that all low-income children are eligible to receive at least the Denti-Cal scope of benefits, and that all providers are reimbursed at least at Denti-Cal rates.</td>
<td>Year 1-2</td>
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<tr>
<td>Use funds from the Tobacco Tax Initiative, Proposition 10 (the California Children and Families First Initiative), and the tobacco settlement to expand benefits.</td>
<td>Year 2-5</td>
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To understand different cultures is to acknowledge that human beings are diverse. Not all ethnic groups or cultures accept mainstream beliefs about oral health or mainstream ways to prevent oral disease. Some groups may view symptoms of oral disease as normal phenomena. Disease as defined by dental professionals may differ from illness as defined by the patient. Different cultures may make decisions affecting their oral health that are contrary to dental practice standards but consistent with cultural values. There are strong links between cultural practices, care-seeking behavior, and receptivity to prevention messages.

Since many beneficiaries of public programs such as Medi-Cal and Healthy Families come from communities of color, programs intended to increase access to care and encourage preventive practices cannot hope to be successful if they are not sensitive and responsive to the cultural diversity of California’s population.

**ACCESS: REDUCE CULTURAL BARRIERS TO CARE**

*Programs intended to increase access to dental care must be sensitive to the cultural diversity of California’s population.*

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<td>Develop training materials to educate dental providers about cultural diversity and patients' rights and responsibilities.</td>
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<td>Develop community-based outreach programs and dental care delivery systems that are culturally appropriate for specific communities and build on the communities' strength and diversity.</td>
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<tr>
<td>Develop culturally appropriate messages about the importance of oral health and find the most effective channels for communicating them.</td>
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### ACCESS: REDUCE GEOGRAPHIC AND DELIVERY SYSTEM BARRIERS TO CARE

Rural residents have special problems accessing health services. Rates of individuals with health insurance coverage in rural areas are lower: Because the poverty rate is higher in rural areas, many rural residents cannot afford insurance coverage. They are also more likely to work in agriculture or in small businesses, neither of which usually offers insurance.

The number of dentists per resident is also lower in non-metropolitan counties. Not surprisingly, urban residents are more likely to have dental examinations. Nationally, about 10 percent of all rural residents have never visited a dentist. In California, more than half of rural preschool children have never had a dental visit.

A recent California law created a category of dental professionals called Registered Dental Hygienists in Alternative Practice. These hygienists are allowed to practice in a variety of settings without a dentist’s supervision—for example, in schools, well-child clinics, hospitals, residential care facilities, and programs operated by state and local public health agencies. However, few dental hygienists have changed their status under this licensure because approved training programs do not currently exist.

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<td>Establish procedures to certify dentists who treat children in the Child Health and Disability Prevention Program so that dentists can be an entry point for children into the program.</td>
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<td>Promote the use of Registered Dental Hygienists in Alternative Practice to provide care in settings where dentists are not always available.</td>
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<td>Increase the number of dentists who treat very young children by providing training opportunities for dentists, dental hygienists, and dental students in managing and treating young children and children with special healthcare needs.</td>
<td>Ongoing</td>
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<tr>
<td>Provide reimbursement incentives to dentists for providing more frequent preventive dental care to children from birth through age 5.</td>
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The dental profession has tended to be professionally isolated, perhaps as a consequence of wanting to define itself as a unique profession. As a result, other healthcare professionals tend to be uninformed about what constitutes oral health and when oral health services are needed.

In addition, dentists have relatively little interaction with other types of healthcare providers, external regulatory bodies, and community agencies. As a result, dentists have limited involvement in major health policy issues. The ultimate consequence of the dental profession’s isolation is the lost opportunity to promote general health through oral health and vice versa.

An area where dentistry could clearly contribute is in suspected cases of domestic violence that include child abuse. The area around the mouth is frequently injured in physical child abuse.

**ACCESS: INCREASE THE PROFESSIONAL INTEGRATION OF DENTISTRY**

The isolation of the dental profession exacerbates the separation of general health and oral health.

**HOW TO DO IT**

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<td>Develop a surveillance system that dental providers could use to track and report suspected cases of child abuse affecting the head, face, and neck.</td>
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<td>Whenever appropriate, include an oral injury prevention component in programs to prevent childhood injuries.</td>
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<td>Include dental professionals in state and other task forces, advisory committees, and other bodies convened to study child health access and financing.</td>
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One way to increase access to dental care for school-aged children is through dental programs that are school-based or school-linked. These programs, which may be mobile or physically based at schools, remove financial and other barriers in the existing healthcare delivery system. They take advantage of the fact that children in, or linked to, school settings are an accessible audience.

Few California school health programs currently offer dental services, although school-based/school-linked dental programs have considerable potential. For example, in a state such as Ohio, which has a large school-based dental sealant programs, more than 20 percent of 8-year-olds have received sealants. In California, with few school-based sealant programs, the figure is about 10 percent.

### HOW TO DO IT

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<th>Expand existing school- and community-based dental programs to more schools, to more grades, and to special education programs.</th>
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<td>Add dental sealant and other preventive services to existing school-based/school-linked programs, and develop new programs at community clinics and migrant health centers.</td>
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<td>Encourage the dental plans participating in Denti-Cal and Healthy Families to pay for preventive dental services in school-based and school-linked settings.</td>
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<td>Establish a referral system between school-based/school-linked dental programs and community care providers of all kinds to give children continuity of care.</td>
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The Oral Health of California’s Children: Halting the Neglected Epidemic

**EXPAND EFFORTS TO PREVENT TOOTH DECAY IN VERY YOUNG CHILDREN**

We now know that tooth decay can begin as early as a month or two after a child’s first teeth have erupted. We also know that parents and caregivers can transmit cavity-causing bacteria to young children. The California Oral Health Needs Assessment found that about one-third of the state’s preschoolers had at least one tooth that was decayed or filled, and one-quarter had untreated decay. Low income children suffer most: Preschoolers in Head Start programs had decay rates 165 percent higher than those of other children.

*Early Childhood Caries* (formerly referred to as “Baby Bottle Tooth Decay”) can require extensive restorative treatment and extraction of teeth at an early age. Treatment is often traumatic for the child, and the cost of restoring the teeth alone may exceed $1,000 per child. General anesthesia, deep sedation, or hospitalization may be necessary because very young children cannot cope with the required procedures. These services can add between $1,000 and $6,000 to the cost of care.

Chronic pain from cavities can keep very young children awake, affecting their well-being and their ability to concentrate. Early tooth loss and associated pain can impair speech, increase absence from school, damage a child’s self-esteem and ability to concentrate, cause psychosocial problems, and even stunt physical development.

*Early Childhood Caries* can be prevented. But because the disease is usually not life-threatening, public health officials have invested few resources in prevention efforts. We need organized community efforts to stop this disease.

Today, there are several ways for a child to enter the healthcare system—for example, pediatricians’ offices or programs such as the Women, Infants, and Children Special Supplemental Nutrition Program. But unless these entry points include oral health as part of their initial screening, a child will receive dental care only when disease is already well established.
Tooth decay can begin as early as nine months...

...and can even stunt a child’s physical development.

**HOW TO DO IT**

| Train healthcare providers, staff in state-supported programs, workers in adolescent pregnancy and teen parenting programs, and parents how to prevent and recognize oral diseases and where to refer children for care. | Year 1-2 |
| Develop education programs for parents and caregivers to encourage breastfeeding, appropriate use of nursing bottles and pacifiers, and restriction of sugary foods and drinks. | Year 1-3 |
| Promote community-based prevention programs that emphasize screening for and treating early childhood cavities; using fluoride varnishes; and treating parents and other caregivers to prevent children’s exposure to cavity-causing bacteria. | Year 1-3 |
| Develop mass media awareness campaigns about how to prevent cavities in young children. | Year 2-4 |
| Work with the legislature, the governor, and administrators of Denti-Cal and other state-funded programs to ensure that the oral health needs of young children are met. Tools for doing this include earlier and more frequent preventive care for children under age 5, training dentists on atraumatic restorative techniques, and helping dentists learn effective techniques for managing very young children. | Ongoing |
The American Cancer Society estimates that more than 30,000 new cases of oral and pharynx cancers will be diagnosed in the year 2000, and nearly 8,000 people will die of these diseases. Between 1992 and 1996, there were 16,000 new cases in California alone, and more than 4,000 deaths. Oral and pharynx cancers account for almost 4 percent of all malignant cancers, and tobacco use is the major risk factor in this phenomenon.

Prevention efforts should include information about smokeless tobacco (tobacco that is chewed or dipped), which directly affects the health of the oral cavity and the pharynx. Recent research clearly links use of smokeless tobacco to oral cancer, and perhaps to cardiovascular disease.
More than 80 percent of tobacco users begin in their teens. Use of smokeless tobacco begins at an average age of 9. These sobering facts suggest that the most effective early prevention efforts will be school-based.

## HOW TO DO IT

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<tr>
<th>HOW TO DO IT</th>
<th>WHEN</th>
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<tr>
<td>Support mass media campaigns to publicize the risk of oral disease associated with using tobacco, and encourage dental organizations to promote positive role models (persons who do not smoke or chew) in their campaigns targeting youth.</td>
<td>Year 1-3</td>
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<tr>
<td>Develop a statewide research program to study the cost of preventing versus treating oral health diseases associated with using all forms of tobacco.</td>
<td>Year 1-3</td>
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<tr>
<td>Conduct a prevalence study of chewed and dipped tobacco use, and target programs accordingly.</td>
<td>Year 1-3</td>
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<tr>
<td>Encourage dentists to give their tobacco-using adolescent patients advice about quitting, to feature no-tobacco-use messages in their waiting rooms, to become resources for school assemblies, and to provide media messages that highlight the link between tobacco use and oral disease.</td>
<td>Ongoing</td>
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REFERENCES


4 Centers for Disease Control and Prevention, Division of Oral Health. Personal communication May 2000.


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