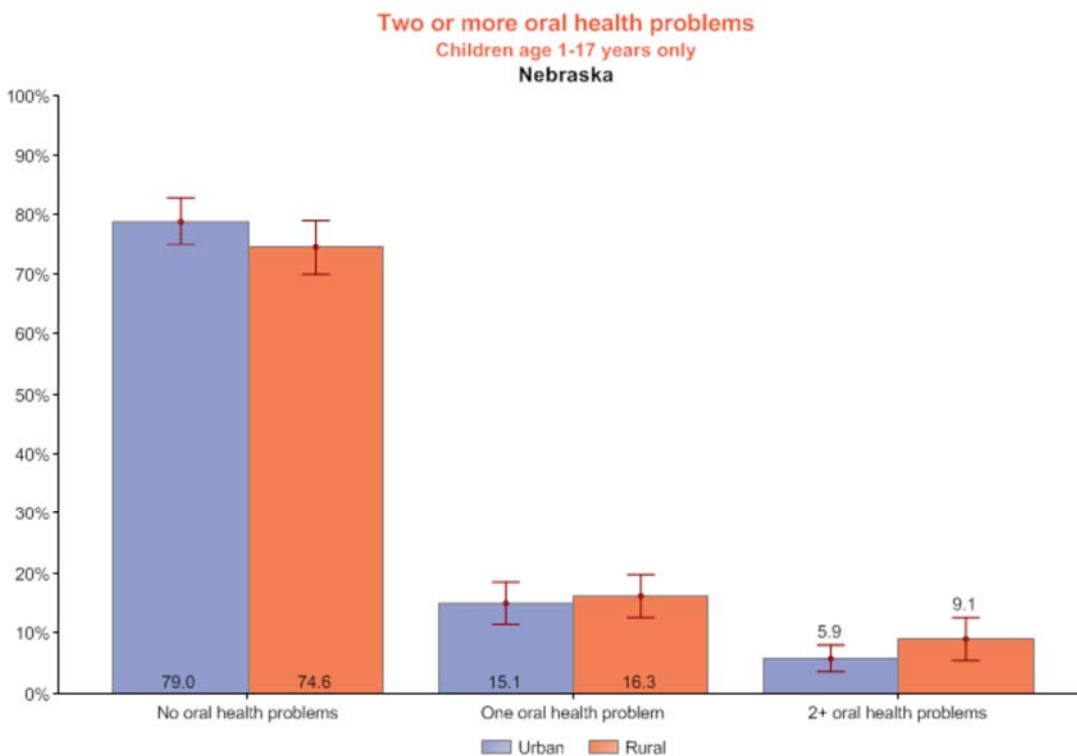


Access to Oral Health Care for Nebraska's Children

Oral Health is an essential part of everyday life and enhances our ability to speak, smile, smell, taste, touch, chew, swallow, and convey emotions. Oral diseases range from cavities to oral cancer. Poor oral health affects children's ability to learn, potential to thrive, and quality of life.

The Oral Health Access for Young Children Program Final Report January 2011 to August 2012, issued by the Nebraska DHHS Office of Oral Health and Dentistry, identified the following issues:

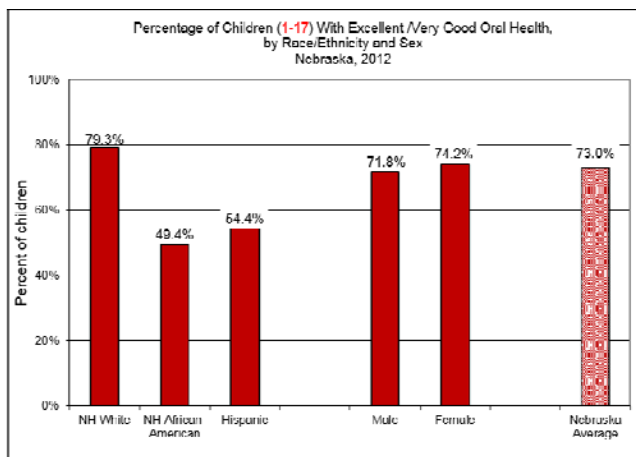
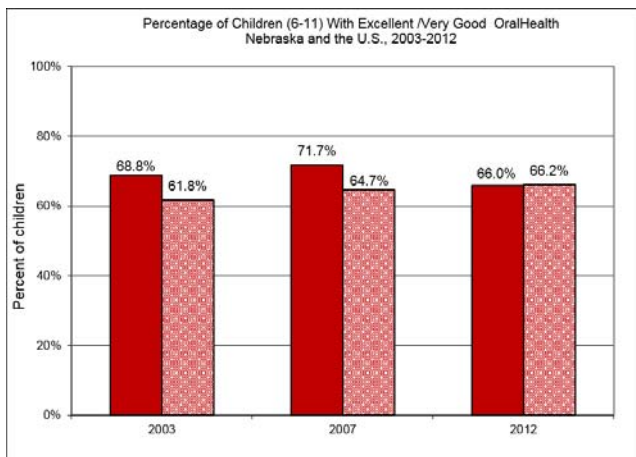
- Children living in rural areas of Nebraska are more likely to have oral health problems.
- Children without private insurance are more likely to have poor oral health.
- Nebraska Children whose primary language is not English are over 10 times more likely to have poor oral health.
- Of 43 pediatric dentists in 2011, only seven (16.3%) were located outside of Omaha and Lincoln.
- Fluoride varnish can effectively prevent tooth decay in high-risk children.



A lack of pediatric dentists, shortages of funding, and lack of coordination of existing efforts are some of the contributing factors to the poor oral health status of some of Nebraska's children.

Criterion 1: The Problem is Worse than the Benchmark or Increasing

In Nebraska, 21% of urban and 25.4% of rural children (ages 1-17) have one or more oral health problems. 20.7% of Nebraska’s Non-Hispanic white children, 50.6% of Nebraska’s Non-Hispanic African-American children and 45.6% of Nebraska’s Hispanic children in the same age group are reported to not have excellent/very good oral health. (National Survey of Children’s Health)



The drafted 2015 Oral Health State Plan identifies five main focus areas to direct program efforts towards future improvement: Public Policy, Surveillance, Access to Dental Care, Community Prevention, and Health Promotion.

Nebraska’s Vision for Oral Health, according to the drafted Nebraska Oral Health State Plan is: “Nebraskans, including health care professionals, parents, educators, funders, lawmakers and policy

makers, recognize the importance of oral health to overall health across the lifespan by adopting good oral health behaviors and by supporting policies and programs to provide access to optimal oral health care and dental homes for all.

Criterion 2: Disparities Exist Related to Health Outcomes

Disparities present in a variety of ways. While oral health data is limited, available data showing the picture of oral health for Nebraska’s children identifies very evident oral health disparities for race, ethnicity, income level, and rural geography.

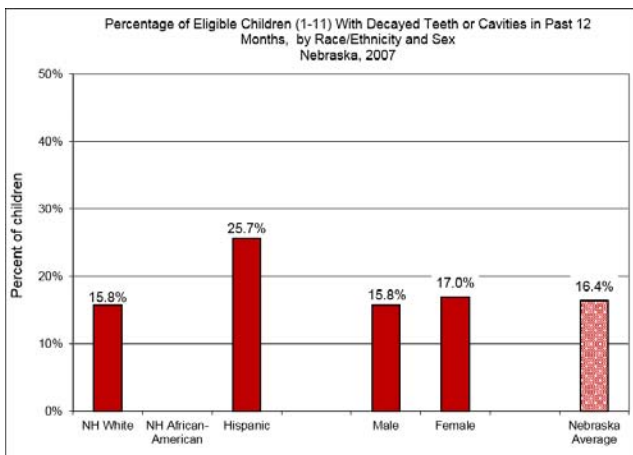
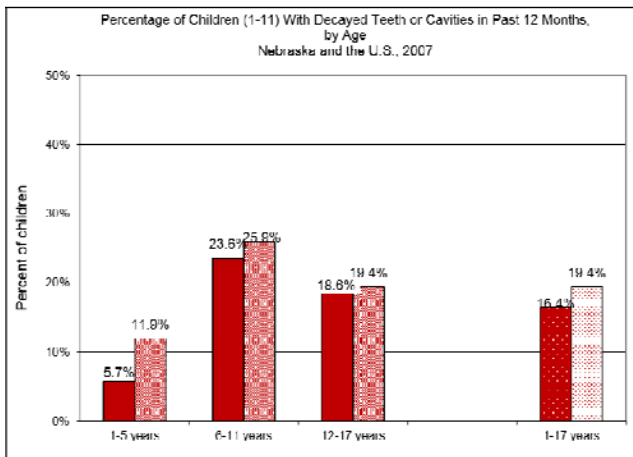
Only slightly more than half (55.8%) of Nebraska’s Medicaid children, ages 1 – 9 years, received any preventive dental care in 2013. (Medicaid/EPSTDT)

While 15.8% of white Non-Hispanic children ages 1-11 years had decayed teeth or cavities in 2007, 25.7% of Hispanic children in the same age group had decayed teeth or cavities. (NSCH)

According to the Nebraska 2005 Open Mouth Survey of Third Graders, African American and Hispanic children and children from low-income schools have significantly higher treatment needs (including rampant caries) compared to non-minorities and children from higher income schools.

The Voices For Children, Kids Count 2014 report states, “...trends show troubling disparities in our poverty rates based on race and ethnicity. In the most recent year for which we have data, child poverty decreased slightly for white children in Nebraska and increased slightly for children of color....While the number of families living below poverty is gradually decreasing, the number of children living in low-income families is increasing.” ““Median income also varies greatly by race and ethnicity with white non-Hispanic households having the highest median income of each racial group [\$54,212] making nearly twice as much as the median household income of Black/African-American households at the bottom [\$27,786].””

Healthy People 2020, Oral Health Objective 8: “Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year.”



Criterion 3: Strategies Exist to Address the Problem/An Effective Intervention is Available

The American Academy of Pediatric Dentistry and the American Dental Association recommends the first dental visit to establish a dental home should occur within six months after the baby’s first tooth appears, but no later than the child’s first birthday. During the first visit the child will be assessed and provided with preventative treatments. The dentist will discuss with the parents how to clean the child’s teeth; nutrition and fluoride needs, and will answer questions regarding the child’s oral health care.

Strong evidence suggests applying fluoride varnish 3-4 times a year and the placement of dental sealants on molar teeth are effective preventive care services that reduces the occurrence of dental decay.

Strong evidence supports fluoridation of water supplies in an effort to prevent tooth decay.

General dentists can be trained/educated on techniques and strategies to serve children with special healthcare needs and young children.

Criterion 4: Societal Capacity to Address the Problem

In 2009 Nebraska Medicaid began reimbursing for fluoride varnish application completed in a physician’s office.

Healthy People 2020 Oral Health Objective 13 is to increase the proportion of the U.S. population served by community water systems with optimally fluoridated water.

- The national baseline was 72.4 % of the U.S. population was served by community water systems receiving optimally fluoridated water in 2008.
- The target for this health objective is 79.6 percent.
- As of 2011, 68.2% of Nebraska’s population was being served by a fluoridated community water system putting Nebraska below the Healthy People 2020 baseline and target numbers.

Currently in Nebraska there are a number of oral health initiatives occurring, but there is a need for coordination of efforts to generate an approach to address the problem in a more systemic manner. For example, multiple leadership committees for various initiatives exist that could be more efficient and far reaching if integrated.

In 2014, the NE Office of Oral Health and Dentistry (OOHD) hired a new Dental Health Director and Dental Health Coordinator/Health Program Manager I. These two positions will play a vital role in the coordination of oral health programs and activities moving forward.

- The OOHD secured Preventive Health and Health Services Block Grant funds to re-establish and support five *Oral Health Access for Young Children* Programs across the state. The *Oral Health Access for Young Children* Program works through partnerships with local public health departments, Head Start/Early Head Start Programs, WIC Clinics, childcare centers,

and Registered Dental Hygienist with a Public Health Authorization to provide dental screenings, fluoride varnish treatments, oral health education, and dental referrals to children 0-5 years of age.

- The OOHD is planning to conduct a basic screening survey of third graders and Head Start students starting in the Fall of 2015.

The Office of Rural Health coordinates several efforts to ameliorate workforce disparities, such as loan repayment, recruitment efforts, and other incentives for dentist who opt to practice in rural Nebraska.

The Nebraska Governor's Rural Health Advisory Commission has designated 49 of the state's 93 counties as General Dentistry Shortage Areas. There are 20 counties without a full time dentist and 85% of the counties are shortage areas for pediatric and oral surgery specialists based on 2013 data.

The uneven distribution of dentists is complicated by the fact that many are nearing retirement age. According to the 2012 data from The University of Nebraska Medical Center's College of Public Health, Health Professions Tracking Service there were 1,034 were actively practicing. 54% of those practice part time and 26% practicing were over the age of 60 and approaching retirement age.

Workforce issues are also being addressed through the Public Health Authorization (PHA) first introduced in Nebraska in 2008 to allow Registered Dental Hygienists to provide preventive oral health services and education to children outside of the traditional dental setting.

- In 2008 a dental hygienist needed to have proof of a Nebraska license, liability insurance, and 3,000 clinical hours of experience.
- In September 2013, the public health authorization certificate was modified creating two versions, Child Only and Child & Adult.
 - For the Child Only public health authorization a dental hygienist needs to have proof of a Nebraska license and liability insurance.
 - For the Child & Adult public health authorization a dental hygienists needs to have proof of a Nebraska license, liability

insurance, and 3,000 clinical hours of experience.

- Both PHAs require a report be submitted annually about the services provided by the registered dental hygienists.
- Under the PHA the following services are allowed: oral health education; preliminary charting and screenings; oral prophylaxis to healthy children who do not require antibiotic premedication; pulp vitality testing; and preventive measures, including the application of fluorides, sealants, and other topical agents for the prevention of oral disease.
- Services can be provided in health care or related facilities, or public health settings. According to Nebraska Revised State Statute §38-1130 this includes: a hospital, a nursing facility, an assisted-living facility, a correctional facility, a tribal clinic, or a school-based preventive health program, a federal, state, or local public health department or clinic, community health center, rural health clinic, or other similar program or agency that serves primarily public health care program recipient.
- As of March 2015 there are a total of 80 registered dental hygienists with a public health authorization (71 child & adult/9 child only).

Nebraska's dental colleges support a number of safety net oral health projects such as Dental Days, Mission of Mercy, etc., which periodically provide oral health services to underserved populations in different communities across NE. The wait time and number served is extensive, indicating the need for ongoing oral health services in NE.

Criterion 5: Severity of Consequences Criterion

Oral pain has devastating affects upon children and untreated cavities and other oral health issues not only cause pain, but also dysfunction, school absences, difficulty concentrating, and poor appearance, social development, speech development problems that greatly affect a child's quality of life and ability to succeed. "Tooth decay affects more than one-fourth of US children aged 2-5 years and half of those aged 12-15 years. In lower-income families, about half of the children and two-

thirds of adolescents aged 12-19 years have had decay. Children and adolescents of some racial and ethnic groups and those from lower income families have more untreated decay'. (Center for Disease Control and Prevention- CDC) According to the Maternal and Child Oral Health Resource Center, an estimated 52 million school hours or 850,000 school days are lost nationwide per year because of dental-related illness.

According to a Nebraska Dental Claims FY 2014 billing report, there were billings from 74 of Nebraska's 93 licensed providers for 157,067 patients (adults and children) and 307,481 visits for a cost of \$40,665,871.00. Considering that Nebraska has a population of 457,097 children between the ages of 0-17 years of age and an average of 235,523 children eligible for Medicaid/Children's Health Insurance Program it appears that a significant number of Nebraska's children are not receiving oral health care.

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CDC Centers for Disease Control and Prevention: Children's Oral Health, Disparities in Oral Health, State-based Oral Health Program: Community Water Fluoridation; Community Based Initiatives to Promote the Use of Dental Sealants; School-based Dental Sealant Delivery Programs

Voices For Children, Kids Count 2014

Healthy People 2020

Oral Health Access for Young Children Program Final Report January 2011 to August 2012

National Survey of Children's Health

Draft 2015 Nebraska State Oral Health Plan

Notes: Data was obtained from Nebraska Medicaid and the National Survey of Children's Health (NSCH).

Nebraska Medicaid data is derived from the annual EPSDT (Early Periodic Screening Diagnosis, and Treatment) Participation Report, Form CMS-416. EPSDT is the child health component of Medicaid. It's required in every state and is designed to improve the health of low-income children, by financing appropriate and necessary pediatric services.

The NSCH is a national survey that was conducted by telephone in English and Spanish during 2003-2004 and for a second time in 2007 and in 2011-2012. The survey provides a broad range of information about children's health and well-being collected in a manner that allows for comparisons between states and at the national level. The survey results are weighted to represent the population of non-institutionalized children 0-17 nationally and in each state.