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: ... discuss history of the oral health program in West Virginia. Current program initiatives. Define and discuss the importance of collective impact on project success. Preemployment. Children's. Dental health

project. Fluoride mouth rinse and water testing. Epidemiologist. Surveillance. Marshal university. Coalition. Chronic disease. Potential federal award. Oral disease prevention. Recruitment. Perinatal and children's initiatives. Prenatal. ...

SPEAKER: Again thanks Luke and of course we like to enjoy the opportunity and appreciate the opportunity to talk about our program. And today really that's the goal I want to cover as much. The three of us want to cover as much material, share as much material about the program. Just to give you some overall background, some knowledge of what we're trying to accomplish. We started back in 2009. Can you all hear me fine or is there feedback?

SPEAKER: Please remember to mute your line. Okay try that. Did immut you too?

SPEAKER: How about now do you hear me?

SPEAKER: Yes.

SPEAKER: I'm just talking away.

SPEAKER: Sorry.

SPEAKER: In 2000 and nine I'll start back at 2000 and nine thankfully oral health became a priority in West Virginia. Basically centered around a report. Gave some attention and gave oral health the priority here in West Virginia. There were some policies that needed to be in place and some specific infrastructure. In 2010 I became the state dental director in 2010. One of our programs is ipDTH. It's in the office of internal child family and health. Most of the programs related to kids. Around the country oral health -- if you've seen one state you've seen one state. Typically they'll either set in your MCH programs or it'll be in chronic disease programs. The acceptor for disease control is actually -- inaudible. The one thing when I first started you look at other states and you look at the report and you look to see what you've got to put in place and basically you start with trying to put some infrastructure in place, you have to have a state plan, you have to have a surveillance system

and you have to have a coalition. And basically that's where we spent the majority of our time just trying to get certain pieces in place. We got our first Grant from the foundation. Basically we use that funding to try to get set, the stage for that next CDC Grant. I'm not going to talk about all the grants specifically but I will tell you that we've been -- we've done a great job when it comes to applying for federal funding. We received about every Grant out there prior to 2016 we got every Grant available. In the last couple years we missed a couple but we've done a fairly good job of securing funding for our state.

I'm going to skip on. As far as the kids, yeah you're right. So when we do surveillance our surveillance plan is basically -- we try to do a certain age population every year and basically we have our universal population is one. We have our third grade -- we have older adults and then we have adult population. We're the only state to do the perinatal population. But one of the main issues that we had was basically the kids are entering school -- about 50 percent have had a

carries experience. A carries experience means that they've had carries. So it could be untreated or treated. Of the ones that have had carries, 21 percent of them have not been treated. So I think we're doing a fairly good job of getting the treatment but we're not doing a real good job here in the state of making sure kids have access to preventive services prior to school age and that's something that's a challenge, there's a lot of challenges but -- even I, I think I'm young but I was trained on an old standard of care, age three. Now we try to get them in at age one. So basically we've got to do a better job of getting kids in for preventative services and throughout this next hour we'll talk about some of the things that we're trying to do. They would only keep approximately six. So things have improved there. Probably the biggest issue we have right now is adults. There's just not a lot of places for adults to go. Primarily because Medicaid only provides emergency benefits for adults. They end up in the ER or at our dental school where they put a big burden on our free clinics and FQHCs. They're not dispersed across the province and the public sector. Majority is

all going to the private sector programs. Didn't address adults.

Actually we don't even have to provide out of state provides emergency services. But this is something that some states have access to. That's something we're trying to do here. One just because with their kind of disease. If you've got an infection I don't care if it's in the mouth or where it's at but if you're going to manage it you have to manage the entire body. I'm going to let Julie talk a little about the perinatal children.

SPEAKER: Okay. So when I came in a little over three years ago one of the big grants was the merse aGrant. It was the perinatal quality improvement. We were one of three states awarded. We wanted to establish dental homes at earlier ages and of course we were also seeing a lot of low birth weight or preterm birth. With the Grant it kind of covered all of that. We completed our first ever perinatal screening which showed us what some of the issues were. Some of the things we did with this Grant, we worked with our -- next slide -- as doctor raffle mentioned there was an

emergency only benefit for the med Kate only adults. So we worked with MCOs to figure out how we could at least cover the pregnant women. One of the adds was that pregnant women could go get their teeth cleaned. They didn't really see that as a value because some of the other MCOs were providing -- inaudible. We decided that one of our things was going to be we were going to offer gift cards, 25-dollar incentive. So we contracted with the MCOs to add the value add and we did see a pretty good up take. Actually in one of the corners of reporting we had 33 women who got their teeth cleaned which honestly is really big seeing how in previous years we maybe would have one per quarter or zero. So I think the incentive really helped to get these women in.

SPEAKER: One point that I want to make. I want everyone to understand that you're not born with the bacteria that causes cavities. It's transmitted. Can be transmitted from the mother. So that's why we're trying to put a lot of focus on the perinatal population. Back on the mom and dad in these programs.

SPEAKER: It also sets the stage for visits, good oral health care from birth on that we don't wait until the child is getting ready to start school or we don't wait until they have all their teeth to start brushing. If we start with the pregnant women and educate and get these women to understand that it is important we're hoping it will set the stage for good oral health care early on. You can go ahead and move. This is where we talked about incentives. If you go on to the next.

One of the big things is we did work on the medical dental collaboration and referral. When patients come into a dental office we have no problem taking their blood pressure and referring them to their primary care doctor. One of the big initiatives was working with our medical provider for an example with the OD provider to get them to send their patients to the dentist office discuss oral healthcare. We've really seen a good increase in the collaboration and the bidirectional referral. The next slide is going to talk about early childhood carries and robes going to take over.

SPEAKER: Okay in the next few slides I'm going to review the early childhood stageoffs carries and symptoms for each of those. I do want to reiterate it is a 100 percent preventable disease. If you see there mild, progressing to moderate with brown spot leashens all the way to full severe rampant generalized decay. Next slide. Early childhood carries is an infectious chronic disease. It affects 35 percent of three year old from low income families. Caused by poor eating habits and lack of good oral hygiene habits. Eating habits include constant snacking or bottle or sipe cups, sugary drinks, whether that be throughout the day or taken to bed at night. It does affect teeth that are least protected by saliva. So the top front teeth and the molars in the back. Next slide.

These are not to be confused with enamel defects. Twenty to 40 percent of children have these. It defects the in amyl. Can change the appearance or texture. Weak or chalky in amyl spots. Can affect the thickness of the in amyl. This is not caused by eating habits. It's

developmental. Some of the factors that can cause these include mothers health during pregnancy, if the baby is born premature, medications given to the mother during pregnancy, if the child has early fevers or constant ear infections when younger or poor childhood nutrition. These can be treated with restrations or extractions if severe enough. This is not caused by lack of -- these are developmental.

We'll start with mild or the first signs. These are our white spot leashens. They're usually at the gingival margin which is right at the gum line. Thin chalky white line on the tooth. That's caused by food sitting at the gum line for too long. Eating food and not brushing their teeth properly. Sit with the gum line, the bacteria in the plaque. A lot of them eat the same sugars we inject. They breakdown the sugar it turns into acid and that starts to wear away, decalcfiat in amyl. If not managed these spots can progress into full-fledged cavities. If habits change they won't go away but they won't get any worse and if they're baby teeth as long as they're maintained they can fall out.

Unfortunately if habits aren't changed they will progress.

As those spots begin to progress the cavity or the hole begins to completey get through the in am. These leashens become dark as they're stained from food. The dental is soften and more cavity prone. So once you start to see these leashens if they're not treat asked nipped in the bud right away the bacteria becomes very prevalent and they will rampantly start to spread throughout the mouth. Once you start to see some of these cavities it's very important to have them treated by a dentist.

Next slide . they're not treat third degree is where you get severe ECC. Multiple dark cavities visible. These are often can be if severe enough abscess or draining first laws at the gum. Unfortunately a lot of children won't be able to verbalize this. They may complain of occasional pain but not constant. They may have trouble sleeping at night and they'll often say they have a bad taste in their mouth or their caregiver will notice a foul odor. Patients with these teeth

will often need treatment under general anesthesia. Unfortunately a lot of times due to those poor habits a lot of parents won't notice that the teeth have gotten to this stage. They'll bring their child in saying that they fell and a tooth has broken off and that is true. But it's usually not just because of the trauma but because the majority of the tooth structure has decayed. How can we prevent these? We need to educate the parents. Babies by their first birthday need to be seen twice per year. We need to review good oral hygiene. The parents must brush for the child. A lot of parents will say little Johnny loves his tooth brush he'll brush four time as day. The parents need to brush. The children aren't going to have the understanding, dex tearity to have proper oral hygiene. We also want them to brush with fluoride toothpaste. I believe the guide line was two years old, they lowered it to one. There really is no need for training toothpaste. Flossing. As well as their eating habits of course. Don't clean babies pas fire with their mouth. Don't share tooth brushes cups utensils. That bacteria, if they're sharing or swapping saliva that's transferg back into the

babies mouth. Avoid any bottles or sipe cups throughout the day or at bedtime. Again it's not as much that the drink is bad for the teeth in my own practice, we used to recommend if they were going to drink juice they could have it at a meal or a sitting but it's the frequency. If you're bathing the teeth with apple juice or drinking it before bed silting on the teeth that's what helps feed that bad bacteria.

How can we manage. Dietary and oral hygiene counseling. Fluoride varnish. Referral to dental home for comprehensive treatment. Again the white spots when you first see those get them to a dentist. Once they have cavities they have to be treated right away. If you see rampant decay there is severe need to avoid infection. I mentioned before varnish. Designed to educate primary care provide answers their staff. Carries risk assessment. Simply apply the fluoride varnish. Target population is ages six month taz three years old who are at a high risk of developing dental cavities. Fluoride varnish training program was initiated to reduce rates of early childhood carries for at risk children.

Administered now by the oral health program. What is fluoride varnish. It's a highly concentrated form of fluoride which is applied to the tooth. Simply painted on. It can be applied by the dentist or another professional. It's easy to apply and sets quickly. It comes in many flavors so it's more appealing especially to children. Available in many colors but most will use a tooth color. Why is varnish important? Tooth decay is the leading chronic infectious disease for children. It's five times more common than asthma. Four times more common than obesity and 20 times more common than -- inaudible. In West Virginia 34 percent have all right have carries. Studies show 25 percent to 45 percent reduction if used fluoride varnish.

Children from birth through six. Especially at high risk. To apply these there's three simple steps. You can apply the fluoride varnish. This can be done four time as year. Twice by a dental provide jury twice by a medical provider. Simply lift the lip and look in the mouth for any signoffs decay. First look for the mild white spots next look for brown spots or cavities. If

you do see rampant decay look around the gum line for any first laws through the abscess. Some key factors to determine if the child is at high risk for cavities. Do you see any white spots or current decay. Has the child ever had a cavity or filling in the past. Have any of the child siblings had a cavity in the past and has the mother or caregiver had cavities. If any of those are yes then that child is at high risk and can and would benefit from fluoride varnish treatment. Obviously you want to refer that child to a dentist. West Virginia Medicaid it's from ages birth to 20 and six months to 18 years. Again there is a code for care providers as well as dental providers. Eligible children can receive up to four applications per year. Two from a dental provider and another two from their nonmedical provider as long as those are separated.

One of these two applications by a pmedical provider is recommended to take place in conjunction with the annual visit. And training for smiles for life, specifically course six is recommended but it's not required for

reimbursement. This sort of gets everyone on the same page for training but it is not required to get reimbursed. Next two slides simply show the Medicaid and West Virginia codes. Nine nine one eight eight. Medical providers. As long as they're separated by six months. D12 oh six for dental providessers. Next slide is same thing for West Virginia chip. Again to participate you can complete the smiles for life curriculum it's free. It is optional. You can conduct your carries assessment. Provide fluoride varnish application. Unlike the fluoride treatments that many of us grew up with where you had to sit with a tray, this is a simple one minute procedure. The varnish sticks to the teeth almost like a glue and the patient ones they leave your office is able to eat and drink right away we just don't have them brush that night. Pretty simple procedure. Again first facts or first birthday is an easy way to remember, first dental visit.

Some extra points that the fluoride varnish program, this project is a program designed for the medical providers and their ancillary taz provide a preventative service. An oral health

preventative service. School age 50 percent of those kids have active decay so we're trying to engage the medical community to provide the preventative services to try to bring those numbers down. The center for disease control, this is community preventative services got community help. The CDC recognizes too evidence based strategies for oral health. One water floor I diddization. Others is sealants. Sealant programs. West Virginia I'll tell you about 90 percent, close to 90 percent of our public water system are chlorinated which is great. The problem is a lot of our kids don't live in those systems. They still do wells. We do provide the little test of those wells and provide supplements if needed. Two strategies is floor I diddization and sealants. A lot of our interventions when it Ms. to school age. We utilize the school system as access points to schools to deliver the sealants. It's estimated there's 51 million school hours missed just from a dental condition. Doesn't only affect overall health but affects our school performance.

SPEAKER: EPSDT chart. In review for Medicaid

medicare services. This is the information shown right here. Annual participation reports from the last year, this is showing you 2012, through 2017 the average utilization for preventative care is 43 point eight. Shows the annual average. Especially in our youngest populations. Epidemic and support for the NCH population and community. You can see we've kind of had a little bit of a rise and a little bit of a fall. They're staying about the same. There's a little bit of enough in a three to five-year-old. We do have the dental business of school entry. Start getting to the 1920 year old it starts falling away. We are trying to work on this population to try to increase the number for preventative care. Next slide. We're talking about substance abuse trends. The number of West Virginia children entering foster care particularly those zero to 35 months old. Children in foster care are now cat gorricly eligible from our state children with special health care needs. They are considered to be -- CFHDM. CYS. Special health care needs. Last completed in 2010. There were estimated a little over 70,000 children special health care needs in West Virginia and the prevalence is one

of the highest in the country. More recent data estimates the number of children with special health care needs is one in four. Which exceeds the national rate of 19. Next slide we're going to talk about the oral disease prevention project. Do one of you want to talk about this?

SPEAKER: Our goal is to increase the number of public school students with sealants. Collaboration with board of education. Topic 2423. We'll go to the next slide. Over the last five years, going into the seventh year, along with board of education, preK kindergarten. We now have all those age groups. Who need to have an oral exam. Next slide goes over the phase in plan to occur over the last few years. Beginning way back in 2014. Starting with preK and kindergarten. Include second grade. Seventh and 12th grade last week. Old health survey. Thirty-seven schools. Third grade. 1100 students receiving screening. 40 percent response rate. Systematic probability. Sample 37 schools. If the school refused to participate randomly selected. Our base line is to reduce the proportion of children who have dental carries

experience in their baby or permanent teeth. Base line was 54 point four. Our results showed 48 point three had decay experience. That refers to having untreated decay or previous fillings crowns or other types of restorative material. We also wanted to reduce the number of children six to nine one treated dental decay. Our results showed 18 point seven percent untreated decay. Dental cavities or tooth decay that have not received appropriate treatment.

We wanted to increase the proportion of children who received dental sealants on one or more of their permanent first molar teeth. Base cline was 25 point five percent of those children. Our results showed that 28 point three had dental sealants in those first molars. Back teeth of molars. Protective barrier. Protect those permanent molars from getting cavities. Eighteen point five percent needed dental care. Two percent needed urgent dental care meaning a child had pain or abscesses. I'm going to turn it back over to Joely to go back over the work force.

SPEAKER: Okay we talked about some of the issues

we had. We don't know where to go. You can get it all on the health dot gov' website. If you want to skip on to the next slide. Currently in West Virginia we have 1392 dentists. This is broken down by county. Next slide dental hygienist by county. The next slide talk business our work force. Raffle had mentioned earlier we only have one dental school in the state, we do have three hygiene schools. We did have 47 graduates this year. Sixteen associates in practices throughout West Virginia. We did have 21 residency programs which 18 plan to come back to West Virginia. Six associates out of state. One military. One out of the country. So we did retain 53 percent or 58 percent coming back so that is a big big improvement. Our next slide one of the issues is we only have 17 board certified pediatric dentists in our state, 15 practicing. They're in the process of opening their pediatric residency program. They have working on that. We're hoping in the next few years we will see more pediatric dentists in our state. Some of the grants we had. We did have a dental work force Grant. This provides a lot of equipment into our dental areas. Where we might be able to see

people but we don't have proper equipment. So with our Grant we were able to provide a lot of these dental offices. To provide additional care. The next few slides show that it it was a three year project. We were awarded 1.5 million dollars. We did end up giving a total of 25 brants through that Grant series. Partners for the center for health and development. They also provided low interest loan taz keep this stuff going, to keep everything afloat. On to the next slide. I'm talking way ahead of the slides here. The next slide.

Some of the other big things that we have promoted. Our state loan repayment program. This is for dental providers. Primary care physicians nurse practitioners nurse midwives physician assistants. They aren't obligated to provide services in shortage areas. Most of West Virginia is considered a shortage area. Will pay to you issuen expenses, just to keep these providers in the area. Next slide. This just talks about some of the criteria that they must meet in order to accept these services. The next one is recruitment and retention community project. It

goes along the lines of state loan repayment. You can read the criteria there. It is up to $20,000 a year for a total of $80,000 if they commit to working in the health care providers. The next slide talked a little built about adesalts some of the seniors. Do you want to go over some of that?

SPEAKER: I think the main thing with adults and seniors is that it's hard to address the children's issues. I'm not going to go into the details, the numbers a caregiver the mother and father. They have bad habits, don't understand the value of oral health it's really hard to have an impact on the child health. In West Virginia by not addressing the adults it's really challenging to have those drastic improvements or impact on the child. We've been successful with some of our projects. Sometimes it's because the parents aren't involved. We're working with some of the coordination programs. That younger age from perinatal population. Head start. I'm not going to talk a lot about adults. I will say with adults it's a burden on our public programs in general. That's where a lot of the state cases go. Especially the challenging cases. I'm going

to leave time for questions. I think particularly when we're talking about children special healthcare needs some of the data we went over that would include that sub set of population that are included in that population. I think what's important to remember you know our foster care kids now are population. But children with special healthcare needs I think it's that much more important for them to have access to the preventative services. If they have the child has decayed a lot of times depending on the situation sometimes it's tough to treat on these children in the private setting. Sometimes the providers don't feel comfortable treating those children. Like I said we only have 1617 pediatric providers. So a lot of the times these cases end up in the ER. Not ER but the OR. And that's an expensive case. Up to $20,000. So I think the important point you don't remember anything else today is really the prevention. Right now the focus is most of the work is restorative care. But we need to put more focus on preventative especially for this specific age group or population. With the goal that they don't need restortive care. And then been we talked about data, talked about

surveillance data that evaluation. Data drives change. I talked about the reports that we had. Just because you have policies in place, infrastructure in place, when you talk about public health it takes time. And it might take 101520 years before we see some of the impacts of some of the work of things that we've put in place. We need to continue to strengthen the relationship between that medical community and dental community. Providers medical communities, much earlier age. And that's something you care more about in years to come. Something that we need to get better at. But reality is we treat the same kids but there's still a disconnect. Talking about Those communications relations have to improve. Not just for the kids but for the adults. I'm going to turn it back over to you because I can talk all day. I know some of you are going to get hungry but if you have any questions we'll try to answer them. I know we covered a lot.

SPEAKER: No this is a great introductory piece for sure and perhaps we can get you back for other things. You are doing a lot. I'll save some

questions I have. But let's open it up. Does anyone have any questions?

SPEAKER: West Virginia coalitions taking the lead. If you are interested in some of those meetings. I have some specific goals and activities you're welcome to.

SPEAKER: Great. I think people have unmuted some of their lines. Anyone have any questions?

SPEAKER: I don't have a question but I really enjoyed the presentation and I thank you for the work that's being done because obviously dental care is a huge issue in our state and I know even with our clients the funds for you we use a lot of that for dental care. So just thank you for what you're doing.

SPEAKER: Thank you.

SPEAKER: I don't have a question either but I do want to thank you for this because I do have a special needs son and dental care has been a major issue because he has to be put to sleep and he had

issues with anesthesia so therefore he had to be in a hospital setting to have dental care. So that has been an issue his entire life getting good dental care. So this is great that you are doing these things.

SPEAKER: We appreciate you sharing that. Unfortunately our goal is, that's what we want to prevent right. So you sharing those stories helps us kind of move forward with change.

SPEAKER: Knowing that many of our groups many of the individuals on here if not all are listening interact with families in many different ways and families of all ages it kind of gets at that generational piece that you spoke of. What would you advise them to do. Some are seeing them in home visits some are seeing them in the clinics some are seeing them in their schools or other settings. If they see this and they're not doing the assessments per se what should they do? What would be the first things?

SPEAKER: Well the first thing is you know I mean as a family, I mean don't rely on -- I don't want

you to rely on the necessarily rely on the public sector to meet those needs. Take the initiative and take your child to your medical provider for their ePSDT. If they don't provide the oral health piece call them out because they all should be informed of it. I will tell you a lot of them don't do . It so that's one thing. The second thing is you need to go ahead and start taking your child to your dentist by age one. A lot of it is educational. And if the dentist doesn't want to see him call us and we'll find you one who will. Reality is we're all in this together but the one thing I've learned it's hard to change the way someone practs and as far as the dental side a lot of us are changing those standards of care so that it's hard to change that and then the same way in the medical community. It's hard to change the way we practice. The time to do it I think is doing a better job while they're in school. Trying to train together. And that's something to focus on. Don't be afraid to speak out. You do know now that we want your child in there age one. You have as much influence as what we do. Probably more.

SPEAKER: Related to that are there any materials on your website where you would recommend we share. I know we put some things about the dental clinic in the clinic folders but we have a lot of other programs that are outside of our clinics so are there things that we should put in our in take packets relate forked parents and families?

SPEAKER: That's something we can talk about.

SPEAKER: I was going to say I can send you several things that we do give out at health fairs or different health events.

SPEAKER: I can send you stuff.

SPEAKER: Oral healths going to be part of children's special health care needs, part of every program. Actually if you really want to fix oral health. Eventually it's going to be -- the focus has been more on the programs that we have an influence on. But I think change happens through repetition. Hopefully we'll start to see a change.

SPEAKER: We have provided oral health information for all those programs to give and in to the medical community. I can send all that stuff to you. And you can decide what you want to pass along.

SPEAKER: That had be great . we have your approval on that content then just giving everyone some options about from there what they have time for, who they'll be talking to they can pick and choose that had be fabulous.

SPEAKER: Yeah I'll get them together and send them to you.

SPEAKER: What happens with a meadiatric special cyst that they get overwhelmed. Kids wouldn't have to be treated in that setting. Some just don't feel controversial working on young kids. It even makes it that much more challenging when you have a child with special needs. Now we have a child that could've been seen in a private sector. One of these 15 or 16 offices. Time creates more problems. It's a disease process. If not treated it's going to get worse. It's a

continuum.

SPEAKER: It looks like you're making great strides. So we're over three. Does anyone have any other pressing questions. I don't want to --

SPEAKER: She had mentioned a website earlier but I didn't catching what the website address was. I think it was Julie.

SPEAKER: It is www. D -- it's the very last slide. That has some of the information but I can send additional information to Leslie and if she wants to pass it along. Right there at the very bottom. Www dot dhhr dot wv dot g o v slash oral health.

SPEAKER: And we have done work specific to children's special healthcare needs like the clinics dental hi jeppists or dental provider. But the big thing is we are helping support the new pediatric provider.

SPEAKER: You have several of our positive behavior support services program on here watching

this. I know that in the past we've had an OT faculty member who's specifically trying to design program make dental visits a little easier for children on the autism spectrum. And so together I think that would be a spot that that team is skilled on the behavioral side and then with some interest in other programs maybe. If that ever comes up and we have the opportunity to expand that.

SPEAKER: I'll just tell you now we're going to need some help. As far as that program. One of the requirement is a clinic. We can treat those kids there at the hospital. Clinic and the hospital.

SPEAKER: Great. Definitely more to come. We're over. I appreciate your time and patience as we got this started this was really interesting so thank you and thanks everyone for joining us.

SPEAKER: Thank you. We'll be more happy to talk anytime. And we can dig in to one specific area. We covered as much as we could today. But we do appreciate the opportunity.

SPEAKER: More to come for sure.

SPEAKER: All right thank you.