

West Virginia Oral Health Plan 2010 – 2015



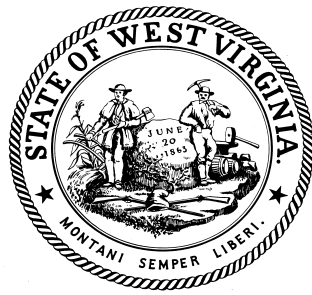
March 2010



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Charleston, West Virginia*

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WEST VIRGINIA
ORAL HEALTH PLAN
2010 - 2015



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Burden of Oral Disease

National Landscape

Oral diseases are progressive and cumulative and become more complex over time affecting our ability to eat foods we choose, how we look, and the way we communicate. These diseases can affect economic productivity and compromise our ability to work at home, at school, or on the job. Many children and adults lack dental insurance and financial resources limiting the ability to seek regular dental services.

Parental awareness, public and private dental coverage, and availability of dental providers, especially for children receiving Medicaid, are critical factors in children obtaining needed dental care. Even though children enrolled in Medicaid are individually entitled under the law to comprehensive preventive and restorative dental services, dental care utilization for this population is low. The reasons for low utilization are many, but a lack of dental providers who participate in Medicaid is a key factor. Few dentists participate in Medicaid – less than half of all active private dentists in some areas. Low reimbursement rates, patient no-shows for appointments, complex forms and burdensome administrative requirements are commonly cited by dentists as reasons for not participating in Medicaid.

State policymakers are increasingly focused on children’s oral health as a major policy issue, spurred in part by the 2000 U.S. Surgeon General’s Report on Oral Health, the high profile death of a child from consequences of a preventable dental infection, and expanded dental provisions in the reauthorization of the Children’s Health Insurance Program (CHIP). This heightened focus on children’s oral health is reflected in new legislation, press coverage, and efforts by state and local oral health coalitions to advance improvements in children’s oral health policies and programs. Policy activity has resulted in both successes and frustrations as oral health competes for scarce resources and the costs of both appropriate and inappropriate dental care continue to escalate. Efforts to reform health care present a significant opportunity to address the resurgence of childhood tooth decay among key populations of children.

Children’s oral health is essential to child development and optimal overall health and wellbeing – a critical part of achieving key developmental milestones and functions including eating, speaking, and attaining normal social and emotional development. Tooth decay, despite being preventable, remains the single most common chronic disease of U.S. children, affecting 26% of preschoolers, 44% of kindergarteners, and half of all teens. Low-income and minority children are particularly affected as they experience the highest rates of this disease yet have the lowest rates of dental care. Poor oral health can have significant effects on overall health, particularly in adulthood, and has been associated with heart and lung diseases, stroke, and low weight births. In fact, the legacy of poor oral health in childhood is reflected in the health of young people entering the military. The Department of Defense reports that 42% of new army recruits could not be deployed until their dental problems were addressed.

Dental caries – the disease process that causes cavities – is largely preventable, highly manageable, and chronic. It is a complex disease process involving the interplay of diet, fluoride, and genetics that results in individual levels of risk for cavities. A family history of dental caries, lack of appropriate fluoride exposure, and frequent sugar intake are among the key risk factors for tooth decay.

According to the National Oral Health Policy Center, *Trendnotes*, October 2009, the decline in dental caries among children has mainly been due to successful, well-established public health strategies that include community water fluoridation, dental sealant programs, and public education and awareness campaigns. Long-standing, community-based public health strategies also have been successful in providing a return on public investment for those who are at the greatest risk. Cost savings include the following:

- Dental costs for children enrolled in Medicaid for five continuous years who have their first preventive dental visit by age one are nearly 40% less (\$263 compared to \$447) than for children who receive their first dental visit after age one.
- For every one dollar invested in community water fluoridation, \$38 in dental treatment costs are saved.
- School based dental sealant programs save costs when they are delivered to children at high-risk for tooth decay.

When children lack dental coverage and access to regular check-ups, dental care frequently waits until symptoms such as a toothache are severe and facial abscesses occur. In these cases, care is often sought in an emergency department where it is costly and likely to be limited to treating the immediate symptoms but not the underlying problem.

Dental sealants - plastic coatings applied to the chewing surfaces of the back teeth where most decay occurs - are a safe, effective way to prevent cavities. Yet, only about one-third of children ages six to nineteen years have sealants. Although children from lower income families are almost twice as likely to have decay as those from higher income families, they are only half as likely to have sealants.

The following are highlights of oral health data for children as reported from the 2003 U.S. Department of Health and Human Services, National Call to Action to Promote Oral Health and the 2009 National Center for Chronic Disease Prevention and Health Promotion.

- Dental caries (tooth decay) is the single most common chronic childhood disease – five times more common than asthma and seven times more common than hay fever.

- Tooth decay affects more than one-fourth of U.S. children age two to five and half of those ages twelve to fifteen. About half of all children and two-thirds of children age twelve to nineteen from low income families have had decay.
- Tobacco-related oral lesions are prevalent in adolescents who use smokeless (spit) tobacco.
- Unintentional injuries, many of which include head, mouth, and neck injuries, are common in children.
- Intentional injuries commonly affect the craniofacial tissues.
- Professional care is necessary for maintaining oral health, yet twenty-five percent of poor children have not seen a dentist before entering kindergarten.
- Medical insurance is a strong predictor of access to dental care. Uninsured children are two and one half times less likely than insured children to receive dental care. Children from families without dental insurance are three times more likely to have dental needs than children with either public or private insurance. For each child without medical insurance, there are at least two and six tenths children without dental insurance.
- Children and adolescents of some racial and ethnic groups and those of lower income experience more untreated decay. For example, 40% of Mexican-American children age six to eight have untreated decay, compared with 25% of non-Hispanic whites. Twenty percent of all adolescents twelve to nineteen years currently have untreated tooth decay. (In West Virginia, approximately 41% of children receiving Medicaid receive at least one dental service).

Older Americans make up a growing percentage of the population. As we continue to live longer, the need for proper oral care is vital to maintain natural teeth and enhance the quality of life. Currently, over 60 percent of the U.S. population over the age of 65 have some or all of their natural teeth. Many people think that conditions such as toothaches, tooth loss and dry mouth happen naturally as you grow old. The truth is, most of these conditions result from diseases of the teeth such as periodontal disease and dental caries or side effects of medications. The following are highlights of oral health data for adults and older adults, as reported by the 2003 U.S. Department of Health and Human Services, National Call to Action to Promote Oral Health and the 2009 National Center for Chronic Disease Prevention and Health Promotion:

- Most adults show signs of periodontal or gingival diseases. Severe periodontal disease (measured as six millimeters of periodontal attachment loss) affects about four percent to twelve percent of adults. Half of the cases of severe gum disease in the U.S. are the result of cigarette smoking. Three times as many smokers as people who have never smoked have gum disease.
- Employed adults lose more than 164 million hours of work each year due to dental disease or dental visits.

- For every adult nineteen years or older with medical insurance, there are three without dental insurance.
- A little less than two thirds of adults report having visited a dentist in the past twelve months. Those with income at or above the poverty level are twice as likely to report a dental visit in the past twelve months as those who are below the poverty line.

Older Adults

- Twenty-three percent of 65 to 74 year olds have severe periodontal disease (measured as six millimeters of periodontal attachment loss). (Also, at all ages, men are more likely than women to have more severe diseases, and at all ages people at the lowest socioeconomic levels have more severe periodontal disease.)
- One-fourth of adults age 65 years and older are edentulous, compared to 46 percent twenty years ago. These figures are higher for those living in poverty.
- Oral and pharyngeal cancers are diagnosed in about 30,000 Americans annually; 7,000 die from these diseases each year. These cancers are primarily diagnosed in the elderly with a prognosis of poor for survival. The five-year survival rate for white patients is 56%, for blacks, it is only 34%.
- Older Americans take both prescription and over-the-counter drugs. In all probability, at least one of the medications used will have an oral side effect – usually dry mouth. The inhibition of salivary flow increases the risk for oral disease because saliva contains antimicrobial components as well as minerals that can help rebuild tooth enamel after attack by acid-producing, decay-causing bacteria. Individuals in long-term care facilities are prescribed an average of eight drugs.
- At any given time, five percent of Americans age 65 and older (currently some 1.65 million people) are living in a long-term care facility where dental care is problematic.
- Many elderly individuals lose their dental insurance when they retire. The situation may be worse for older women, who generally have lower incomes and may never have had dental insurance. Medicaid funds dental care for the low-income and disabled elderly in some states, but reimbursements are low. Medicare is not designed to reimburse for routine dental care (West Virginia Medicaid does not provide for routine dental care for adults).

West Virginia Children

West Virginia recognizes the need to improve oral health for its residents, and long-term improvements will begin with the State's children. At this time, there is limited information about sealants and/or caries for children living in West Virginia. However, this document will explore the issues of dental coverage and access of services for children with West Virginia Medicaid and the West Virginia Children's Health Insurance Program.

According to the 2008 West Virginia CMS 416 (EPSDT Participation Report), there were 206,729 Medicaid eligible persons between the ages of zero to twenty. From 2005 - 2008, about 41% of this population received dental services during a one year period. There was some fluctuation in 2006 when dental services spiked to 55.69%. For this same time period and age group, only 35% received any preventive dental service within each year. The following table provides specific information.

Table 1
West Virginia CMS-416 Dental EPSDT Participation Report 2005-2008

Information	Year			
	2005	2006	2007	2008
Total Eligible (Ages 0-20)	210,974	210,181	207,606	206,729
Total Eligible Receiving Dental Services	86,244	117,070	85,108	86,250
Percentage Eligible Receiving Dental Services	40.87%	55.69%	40.99%	41.72%
Total Eligible Receiving Preventive Services	72,973	73,893	73,012	74,326
Percentage Eligible Receiving Preventive Services	34.58%	35.15%	35.16%	35.95%
Total Eligible Receiving Dental Treatment Services	82,201	85,676	84,711	85,866
Percentage Eligible Receiving Dental Treatment Services	40.38%	40.76%	40.80%	41.53%

CMS-416 Dental Participation 2005-2008

Opportunities to Address Dental Caries under CHIP Reauthorization Act (CHIPRA)

On February 4, 2009, President Obama signed into law the reauthorization of the Children's Health Insurance Program (CHIP). Included in the bill are eight major dental provisions that range from mandating dental coverage to encouraging primary preventive care.

The new Children's Health Insurance Program provisions include the following:

- Requires that states provide dental coverage for Children's Health Insurance Program beneficiaries.
- Allows states to provide dental coverage that "wraps" around commercial medical coverage for children who are otherwise eligible for Children's Health Insurance Program. They may have private medical, but no dental insurance. However, children covered by the Public Employees Insurance Agency would not be eligible for this benefit.
- Requires that states report on Children's Health Insurance Program dental program performance.
- Establishes a requirement that parents of newborns be informed of risks for early childhood caries and its prevention.

According to the West Virginia Children's Health Insurance Program Annual Report 2009, there are several significant changes in the new law that are designed to improve the health care that children receive in the Children's Health Insurance Program and impact the current benefit structure for West Virginia Children's Health Insurance Program. In compliance with West Virginia Children's Health Insurance Program Reauthorization Act's requirements, the current dental benefit for enrolled beneficiaries with income that exceeds 200% FPL needs to be changed. Currently, dental services for this group are limited to preventive services and subject to a maximum of \$150 per year. The new dental benefit will include both preventive and restoration services. Restoration services will include a co-payment of \$25 per service.

Between January 1, 2008, and December 31, 2008, West Virginia Children's Health Insurance Program, using HEDIS-Type Data, estimated that of the 8,675 children age two to eighteen years, who were continuously enrolled for the whole year, 8,380 or 96.60% had at least one dental visit during the year. Previous percentages were 96.06% for 2007 and 95.84% for 2006.

Table 2**West Virginia CHIP Enrollment Data 2006-2008**

Information	Age Group in Years					Totals
	2-3	4-6	7-10	11-14	15-18	
Number of Continuously Enrolled Children	474	888	2,448	2,917	2,422	8,675
Number Having Dental Check up Visit	458	869	2,377	2,826	2,308	8,380
% Year 2008	96.62%	97.86%	97.10%	96.88%	95.29%	96.60%
% Year 2007	97.54%	97.58%	97.24%	96.23%	94.17%	96.06%
% Year 2006	96.33%	97.51%	96.70%	95.52%	94.72%	95.84%

2006-2008 WV CHIP Data

The following table shows the 1998 prevalence of tooth decay and sealants in West Virginia children. West Virginia hopes to update this data in 2010.

Table 3**1998 Prevalence of Dental Caries and Dental Sealants in West Virginia**

<u>Dental Caries (Tooth Decay) Experience</u>	Percentages
Children, age eight years	65.6%
Adolescents, age 15 years	66.0%
<u>Untreated Caries (Tooth Decay)</u>	
Children, age eight years	35.5%
Adolescents, age 15 years	32.9%
<u>Dental Sealants</u>	
Children age eight years (1 st Molars)	36.7%
Adolescents (1 st and 2 nd molars) age 14	34.6%

1998 Baseline data taken from WV Healthy People 2010

According to the above data, 65.6% of West Virginia children age eight have experienced tooth decay as well as 66% of adolescents age fifteen. Thirty-five and a half percent of children ages six to eight years have untreated caries, along with 32.9% of adolescents age fifteen. Only 36.7% of children age eight and 34.6% of adolescents age fourteen have dental sealants. Data for children's dental care is not current and difficult to find for West Virginia children.

West Virginia Adults

According to Centers for Disease and Control Prevention (CDC), West Virginia has the highest rate of tooth loss of adults age 65 and older in the nation. With a State that ranks almost last in median income and a high rate of poverty, residents do not rate seeing a dentist as a priority. Government health care plans and private employers often do not offer adequate dental insurance coverage. Medicaid fully covers children up to age twenty-one, but only covers extractions to alleviate pain and suffering for those adults covered under Medicaid. Medicare for the elderly offers no coverage and many times private insurance is offered as a separate policy by companies and employees opt not to pay for it. Unfortunately, some people elect not to continue with regular dental treatment if they have lost their dental insurance or elect not to seek regular dental care if they do not have insurance.

According to the West Virginia Dental Association, transportation is often an issue if a dentist is not located nearby, but a bigger problem is the fact that many West Virginia dentists limit or will not treat Medicaid patients because Medicaid often reimburses less than a procedure costs.

Using data from BRFSS, the following tables look at data over several years in three categories. This gives us an idea of whether improvements have been made across time. Adults that have had permanent teeth extracted decreases with higher education and income levels. The older a person is, the more likely he/she is to have had permanent teeth extracted.

Table 4

West Virginia Adults That Have Had Any Permanent Teeth Extracted

<u>Information</u>	Percentages by Year		
	2004	2006	2008
<u>Percent of ALL adults</u>	61.1%	60.1%	60.3%
<u>RACE</u>			
*Black	N/A	N/A	N/A
White	60.7%	60.2%	60.4%
*Other	N/A	N/A	N/A
<u>GENDER</u>			
Female	62.7%	60.9%	62.0%
Male	59.3%	59.3%	58.4%
<u>AGE in years</u>			
18 - 24 Years	18.6%	18.2%	15.6%
25 - 34 Years	34.9%	36.2%	39.4%
35 - 44 Years	52.9%	52.8%	48.6%
45 - 54 Years	70.8%	65.5%	66.5%
55 - 64 Years	83.5%	78.5%	80.2%
65 + Years	89.8%	90.1%	90.2%
<u>EDUCATION LEVEL</u>			
Less than high school	83.5%	84.0%	81.4%
High school graduate	66.7%	67.6%	68.3%
At least some college	49.2%	53.1%	53.6%
College graduate	42.3%	36.8%	38.4%
<u>INCOME RANGE</u>			
Less than \$15,000	75.8%	82.5%	82.3%
\$15,000 – 24,999	70.3%	75.4%	73.4%
\$25,000 – 34,999	65.2%	67.4%	69.7%
\$35,000 – 49,999	57.3%	54.2%	61.9%
\$50,000 +	45.7%	40.2%	42.2%

Data Source: Behavior Risk Factor Surveillance System (BRFSS)

*Sample size too small to calculate accurately.

Over the past five years, adults age 65 and older have decreased the percentages that have had all of their natural teeth extracted from 44.3% to 37.8%. The percentage is still well above the national average of 18.5%.

Table 5

West Virginia Adults Age 65+ That Have All Their Natural Teeth Extracted

Information	Percentages by Year				
	1999	2002	2004	2006	2008
<u>Percent of ALL Adults</u>	44.3%	41.3%	42.9%	40.5%	37.8%
<u>RACE</u>					
*Black	N/A	N/A	N/A	N/A	N/A
White	44.6%	41.3%	42.6%	40.0%	37.6%
*Other	N/A	N/A	N/A	N/A	N/A
<u>GENDER</u>					
Female	46.2%	43.4%	44.1%	41.7%	38.3%
Male	41.4%	38.2%	41.1%	38.9%	37.3%
<u>EDUCATION LEVEL</u>					
Less than high school	64.3%	60.0%	67.9%	57.3%	59.4%
High school graduate	38.2%	37.0%	39.3%	39.3%	37.8%
At least some college	N/A	32.0%	28.9%	33.5%	30.0%
College graduate	12.9%	16.9%	12.1%	12.4%	12.8%
<u>INCOME RANGE</u>					
Less than \$15,000	62.8%	55.8%	63.0%	62.4%	61.8%
\$15,000 – 24,999	48.9%	43.1%	46.7%	49.6%	43.1%
\$25,000 – 34,999	N/A	N/A	N/A	39.2%	32.7%
\$35,000 – 49,999	N/A	N/A	N/A	15.9%	23.6%
\$50,000 +	N/A	12.6%	11.5%	18.1%	7.7%

Data Source: Behavior Risk Factor Surveillance System (BRFSS)

*Sample size too small to calculate.

The following table looks at the percentage of West Virginians who have visited a dentist or dental clinic within the past year for any reason. Those with higher education and income levels are more likely to visit the dentist with minor variations with age. Females are more likely to visit the dentist than males. Since 2002, there has been very little change in the percentage of adults visiting the dentist or dental clinic.

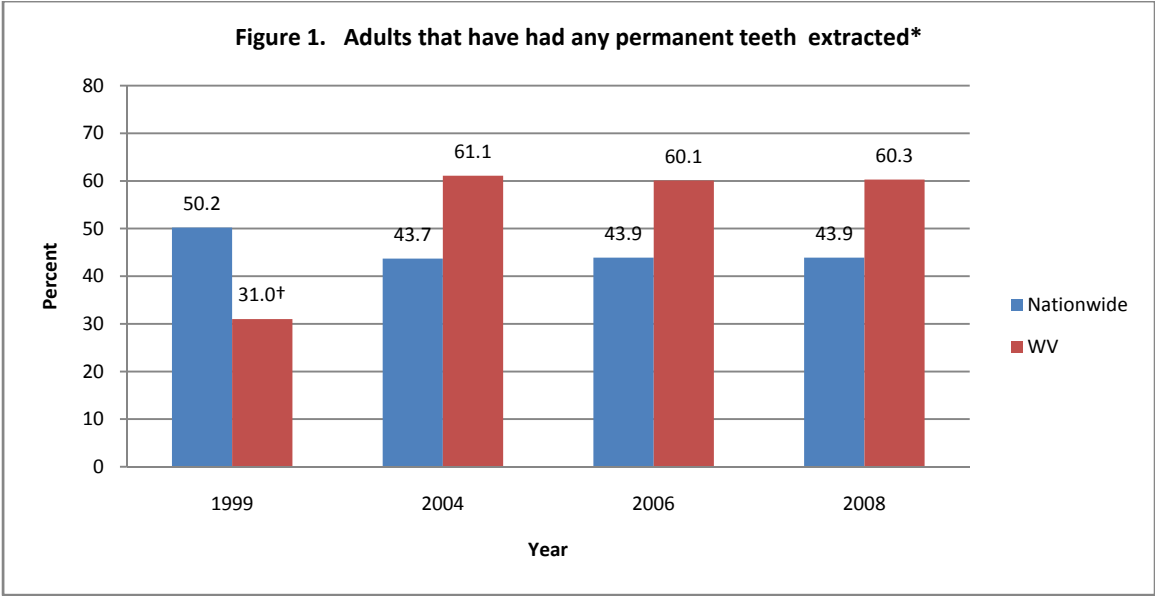
Table 6
WV Adults who Visited Dentist or Dental Clinic within the Past Year for Any Reason

Information	Percentages by Year				
	1999	2002	2004	2006	2008
<u>Percent of All Adults</u>	57.8%	61.2%	62.5%	61.4%	60.7%
<u>RACE</u>					
*Black	N/A	N/A	N/A	N/A	N/A
White	57.9%	61.1%	62.6%	61.0%	60.6%
*Other	N/A	N/A	N/A	N/A	N/A
<u>GENDER</u>					
Female	58.4%	62.9%	63.9%	63.6%	63.9%
Male	57.2%	59.3%	61.0%	59.0%	57.3%
<u>AGE in years</u>					
18 – 24 Years	72.2 %	75.1%	71.9%	72.7%	65.1%
25 – 34 Years	60.4%	64.6%	67.5%	63.7%	61.8%
35 – 44 Years	66.5%	65.8%	61.7%	64.2%	65.6%
45 – 54 Years	61.6%	62.9%	70.7%	64.5%	62.5%
55 – 64 Years	46.1%	57.8%	59.5%	59.8%	58.9%
65 + Years	43.3%	45.7%	47.2%	48.3%	52.8%
<u>EDUCATION LEVEL</u>					
Less than high school	31.3%	35.8%	34.3%	32.6%	37.5%
High school graduate	56.1%	59.1%	58.6%	57.8%	55.4%
At least some college	68.8%	68.7%	73.9%	68.8%	66.0%
College graduate	80.0%	79.4%	81.3%	80.2%	80.3%
<u>INCOME RANGE</u>					
Less than \$15,000	31.3%	35.8%	45.1%	32.9%	33.5%
\$15,000 – 24,999	46.0%	50.8%	48.5%	46.7%	47.2%
\$25,000 – 34,999	59.7%	53.9%	62.1%	55.0%	51.7%
\$35,000 – 49,999	73.4%	72.2%	67.5%	66.1%	64.5%
\$50,000 +	84.8%	81.7%	82.5%	81.5%	80.2%

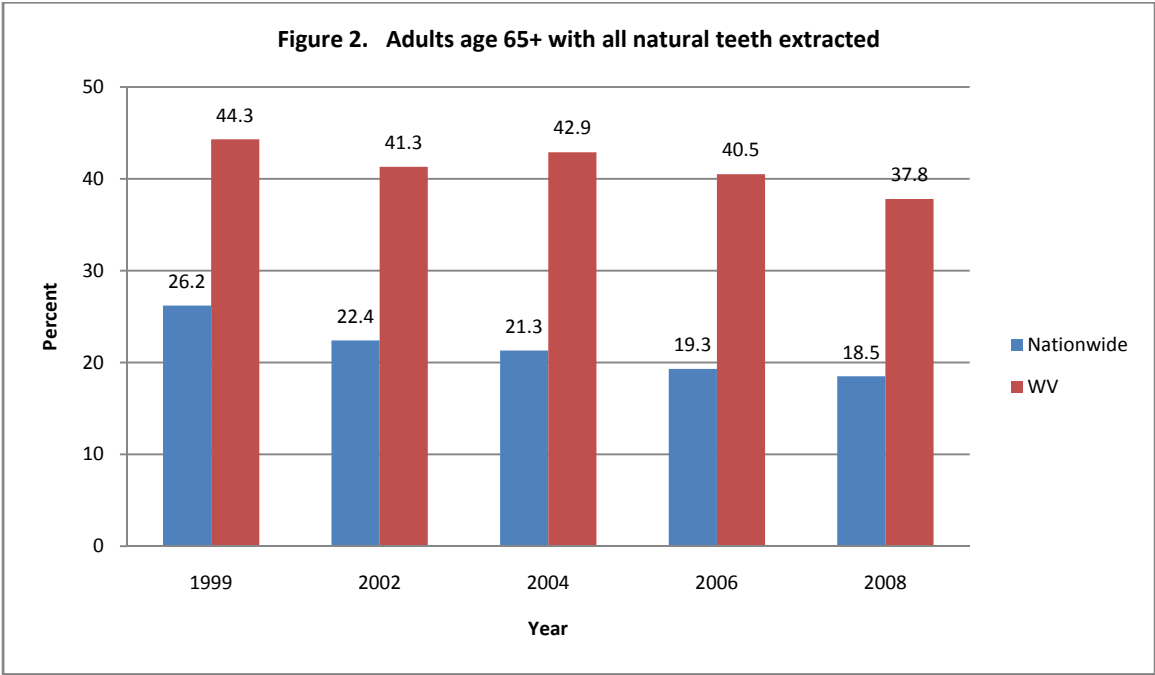
Data Source: Behavior Risk Factor Surveillance System (BRFSS).

*Sample size too small to calculate.

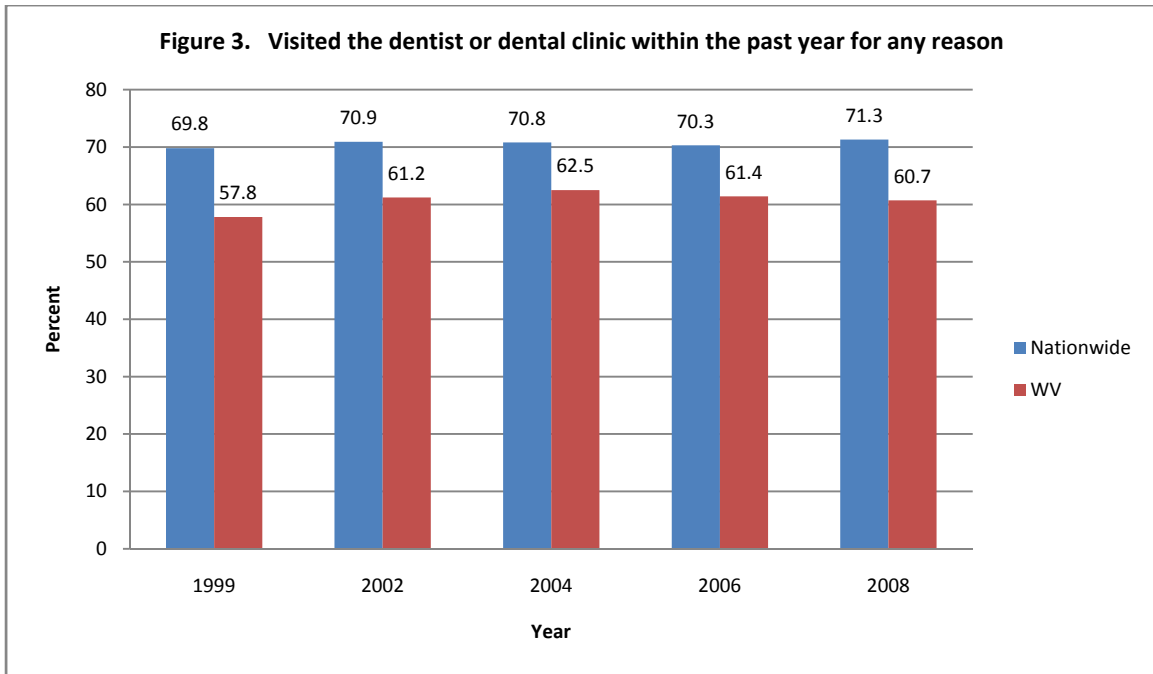
The following bar graphs compare the West Virginia data with national data. West Virginia has a significantly higher percentage of adults that have had any permanent teeth extracted, adults age 65+ who have had all of their natural teeth extracted and a lower percentage who visited the dentist or dental clinic within the past year for any reason.



Data Source: Behavior Risk Factor Surveillance System (BRFSS)
 *2002 data not available.
 †Value may be inaccurate.



Data Source: Behavior Risk Factor Surveillance System (BRFSS)



Data Source: Behavior Risk Factor Surveillance System (BRFSS)

According to the above data, West Virginia lags significantly behind the Nation. The only significant change since 1999 was the percentage of persons age 65+ with all natural teeth extracted. Both the Nation and West Virginia saw a decrease, however, the gap between West Virginia and the Nation remains significant.

Pregnant Women

PRAMS (Pregnancy Risk Assessment Monitoring System) asked women whether they had their teeth cleaned before, during or after pregnancy. The respondent was to answer yes or no to each time period. Below is the yes response rate to each of those time periods.

WVPRAMS Survey Question 83 (Phase V):

When did you have your teeth cleaned by a dentist or dental hygienist? (For each of the three time periods, indicate Yes or No)

- | | | |
|--|----------|----------|
| a. Before my most recent pregnancy..... | Y | N |
| b. During my most recent pregnancy..... | Y | N |
| c. After my most recent pregnancy..... | Y | N |

Table 7

PRAMS: WV Mothers that Reported Having Teeth Cleaned*

Information	Percentages by Year			
	2004	2005	2006	2007
Before Pregnancy	62.6%	63.2%	62.1%	64.0%
During Pregnancy	25.6%	26.4%	27.2%	25.6%
After Pregnancy	23.8%	22.7%	24.1%	21.7%

*Each respondent indicated yes or no for each of the three time periods.
WV PRAMS 2004-2007

Dental Capacity

The Office of Maternal, Child and Family Health administers the Bureau for Children and Families’ Pre-Employment Services Dental/Vision Project that supports these services for persons transitioning from welfare to work. For Pre-Employment Services, the local Department of Health and Human Resources Family Support Specialist will assess if a client may need dental (\$2,500 lifetime benefit limit) and/or vision care. If the client is eligible, a referral will be issued effective for one year. The client receives a list of providers in his or her area that participate in the Program and it is up to them to take advantage of the services. From data in the fiscal system, for the 2009 fiscal year (07/01/08 – 06/30/09), \$1,305,961 was spent serving 1,926 persons for dental benefits and \$218,785 was expended for vision services for 1,319 persons.

Financing for the Program is sound but recruitment of new dental providers and provider shortage in some areas of the state is challenging. The locations of low dental provider participation include: Parkersburg, Lewisburg, Braxton County, and Eastern Panhandle areas and a general lack of participating oral surgeons everywhere. Recruitment has been heavy in all of these areas for several years, but despite not having a lack of dentists in these areas participation is low. For example, Parkersburg has at least 19 dentists within a five mile radius and only one agreed to participate in the Pre-Employment Program. Most dentists who do not agree to participate cite low payments on the fee schedule, especially for oral surgery services, and some mention not wanting to participate in a “State” program because they have had bad experiences with Medicaid payments and clients. A fee increase for Medicaid dental services (and Pre-Employment would follow) has been proposed for several months.

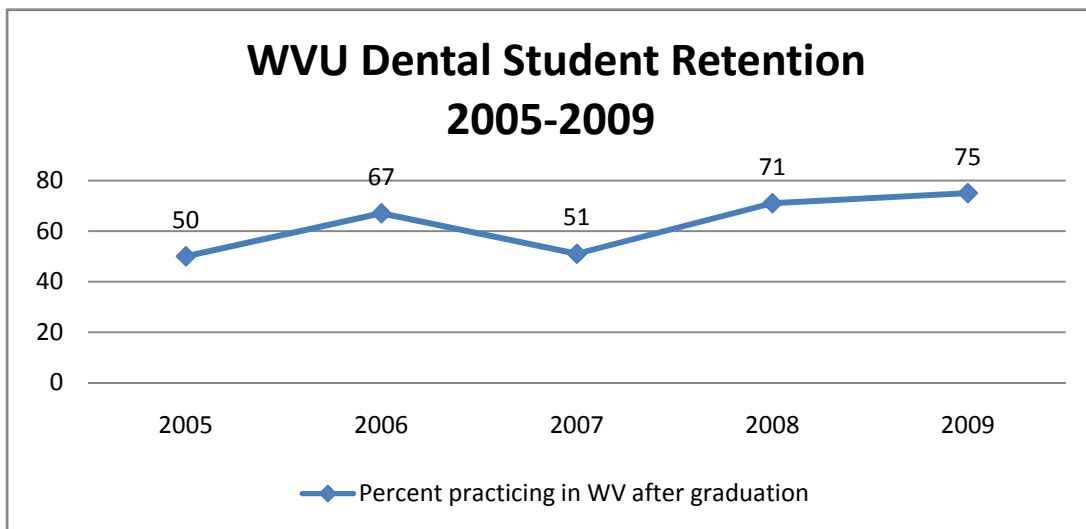
The Office of Maternal, Child and Family Health also administers a small program called the Donated Dental Project in which the dentist donates his time to fit a patient for dentures and is reimbursed for a lab bill up to \$500. Eligibility criteria for patients is – if under the age of 65, must be a Supplemental Security Income (SSI) recipient and 65 years or older, income must be at or below 133% of the Federal Poverty Level (FPL).

As most dentists are charging \$1,000 to \$3,000 for a set of dentures, the program currently has only 65 dentists throughout 34 counties participating and recruitment is difficult. Participating dentists are only required to provide services to one client per year, but some providers like Affordable Dentures in Barboursville and the West Virginia University School of Dentistry provides services to many annually. Funding is limited to \$40,000 a year and can usually provide services to 100 clients per year or \$400 per person. As of January 2010, 245 persons are on the waiting list with funding for the 2010 fiscal year already allocated, essentially halting any new placements until the new fiscal year starts July 1, 2010.

According to the West Virginia Board of Dental Examiners, as of January 2010, there are 854 practicing dentists serving the 1.8 million residents of West Virginia. The West Virginia University School of Dentistry reports that in 2009, 44 students graduated and of those, 33 are currently practicing in West Virginia (75%). The graph below shows an increase in dental student retention of West Virginia University graduates from 50% in 2005 to 75% in 2009.

Figure 4

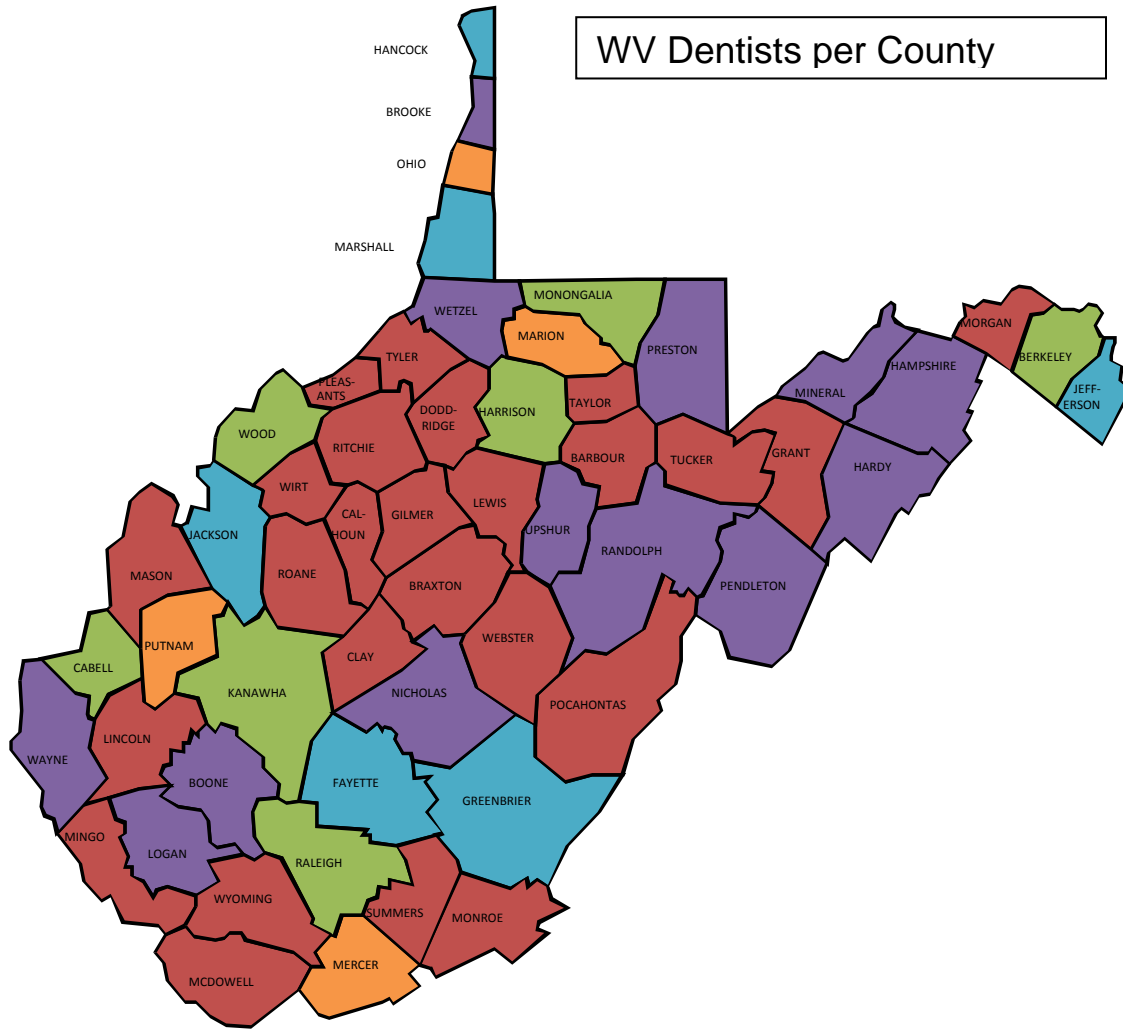
West Virginia University Dental Student Retention 2005-2009



West Virginia University School of Dentistry

The map on the next page shows where dentists are located and a table follows showing the actual number of dentists per county. This information was obtained from the West Virginia Dental Association. The list includes dentists that specialize in orthodontics, periodontal disease, dentures, etc. It is estimated that 50 of the 854 practicing dentists are specialists.

Figure 5



WV Dental Association

Dentists per county:



Table 8*Number of Dentists in West Virginia by County*

County	Number Dentists
Barbour	4
Berkley	47
Boone	6
Braxton	5
Brooke	7
Cabell	53
Calhoun	1
Clay	3
Doddridge	1
Fayette	19
Gilmer	1
Grant	4
Greenbrier	20
Hampshire	8
Hancock	17
Hardy	7
Harrison	45
Jackson	11
Jefferson	12
Kanawha	147
Lewis	4
Lincoln	5
Logan	6
Marion	27
Marshall	13
Mason	5
Mercer	30
Mineral	8
Mingo	4

County	Number Dentists
Monongalia	104
Monroe	1
Morgan	3
McDowell	2
Nicholas	8
Ohio	35
Pendleton	7
Pleasants	3
Pocahontas	2
Preston	8
Putnam	21
Raleigh	42
Randolph	9
Ritchie	1
Roane	3
Summers	2
Taylor	5
Tucker	3
Tyler	2
Upshur	8
Wayne	10
Webster	2
Wetzel	6
Wirt	1
Wood	41
Wyoming	5
Total Dentists	854

2010 Board of Dental Examiners

Some of the 854 practicing dentists in West Virginia provide services through local health departments, free clinics and primary care centers to provide oral health services across the State. The following information describes the locations:

Table 9
County/Local Health Departments Offering Oral Health Services

County	Preventive Services	Educational Services	Medicaid Billing
Grant	NA	Yes	NA
Marshall	Hosts dental clinics in schools	Provides oral health educational materials to school children in Marshall County	yes
Monongalia	A full-time dental clinic is run daily.	Provides oral health education using a grant from the Department of Education. Distributes toothbrushes and paste to students.	yes
Pocahontas	NA	Provides oral health education to Health Department clients	NA
Mid-Ohio Valley	Did a “Mission of Mercy” dental clinic last summer but cannot afford to do yearly. Studying other alternatives to provide services. 18 dentists participated in “Mission of Mercy” effort.	Provides assessments and makes referrals through the school system to local dentists.	yes

FY 2010 Annual Health Department Program Plan

Free clinics offering oral health services:

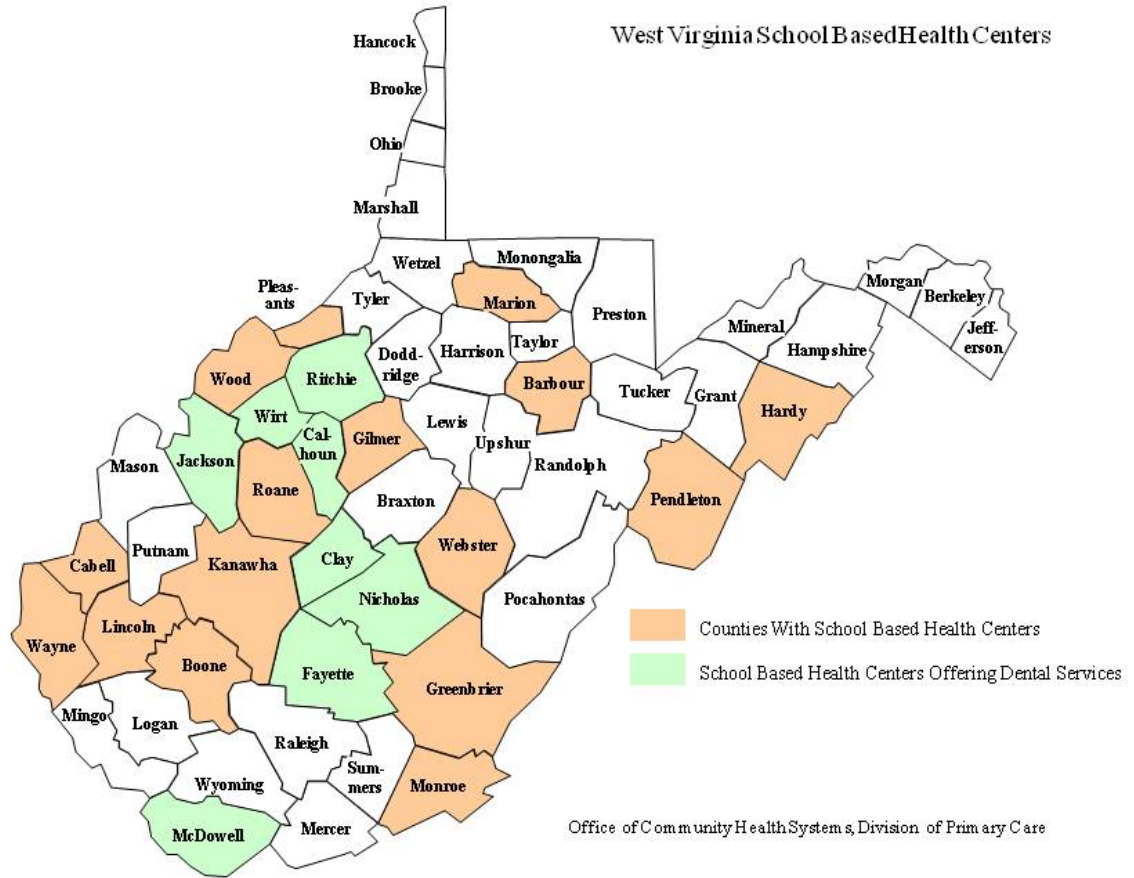
- Three Free Clinics provide direct dental services
 - Ebenezer Medical Outreach, Cabell County
 - Susan Dew Hoff Memorial Clinic, Harrison County
 - West Virginia Health Right, Kanawha County

Primary care centers offering oral health services:

- Ten Primary Care Centers have dental services on site
 - Clay-Battelle Health Association, Monongalia County
 - E. A. Hawse Health Center, Inc., Hardy County
 - Monongahela Valley Association of Health Centers, Inc., Marion County
 - New River Health Association, Inc., Fayette County
 - Preston-Taylor Community Health Centers, Inc., Taylor County
 - Ritchie County Primary Care Association, Ritchie, Pleasants, Wood, and Doddridge Counties
 - Tug River Health Association, Inc., McDowell County
 - Valley Health Systems, Inc., Cabell, Lincoln, Kanawha, Putnam and Wayne Counties
 - WomenCare Inc., Kanawha County
 - Minnie Hamilton Health Care Center, Calhoun and Gilmer Counties

Forty-nine School Based Health Centers serving 61 schools in 24 counties are shown in the following map. (The map was prepared with data provided by the West Virginia School Health Technical Assistance and Evaluation Center, Marshall University, September 2009).

Figure 6



On November 20, 2008, West Virginia Governor Joe Manchin III and the Appalachian Regional Commission (ARC) Federal Co-Chair, Anne B. Pope, announced a major initiative on school-community partnerships to promote children’s oral health in West Virginia. Appalachian Regional Commission and the Claude Worthington Benedum Foundation have collaborated to fund a \$500,000 grant for the program, which will help establish school based dental clinics and will be managed by the Robert C. Byrd Center for Rural Health at Marshall University.

The clinics target school-age youth without access to dental care in the economically distressed, at-risk, and transitional counties of West Virginia. One of the clinics’ responsibilities is to provide sealants to prevent cavities.

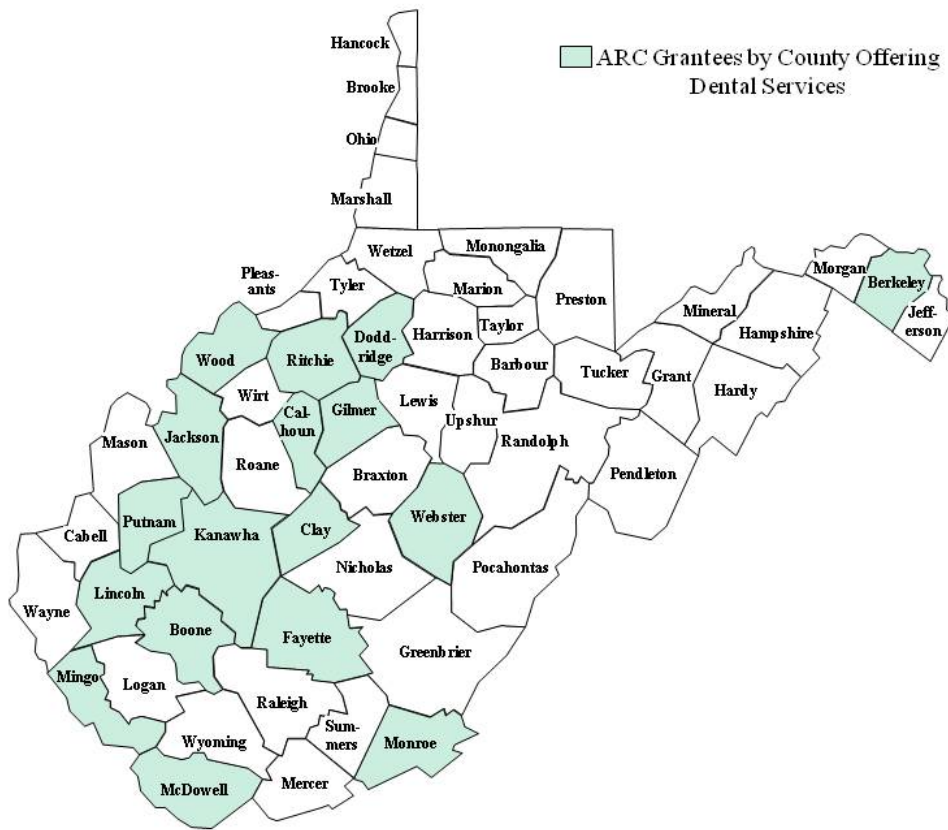
Appalachian Regional Commission funds are used to fund dental equipment requests, and Benedum Foundation funds are used for planning and technical assistance. Schools, health departments, and rural health centers can submit proposals defining their plan and the funding needed to implement a program to expand youth access to oral health care. Approximately 7,500 students will be provided with sealants, exams, and/or restorative care each year as a result of the program. The Appalachian Regional Commission has given out grants of up to \$25,000 to seventeen communities to examine children's teeth, administer fluoride treatment and apply sealants.

Students at Tuscarora Elementary School in Martinsburg come into the nurse's office three at a time. For some of these children this was their first visit to the dentist. Dr. Lisa Dunn is conducting the exams and plans to examine children on free and reduced lunch at every school in Berkeley County whose parents give permission. Dunn refers those who need more care to the new Healthy Smiles Clinic, a sliding scale dental practice that opened in Martinsburg.

Dunn says she sees a lot of children who have one or two cavities and others with more serious problems. "I saw a young man the other day, I'm going to guess he was 10 or 11 because it was an intermediate school and every primary or baby tooth that he had left in his mouth but one needed to be extracted," Dunn said. "So it was very serious."

The following map displays the counties in which the Appalachian Regional Commission/Benedum grantees are located.

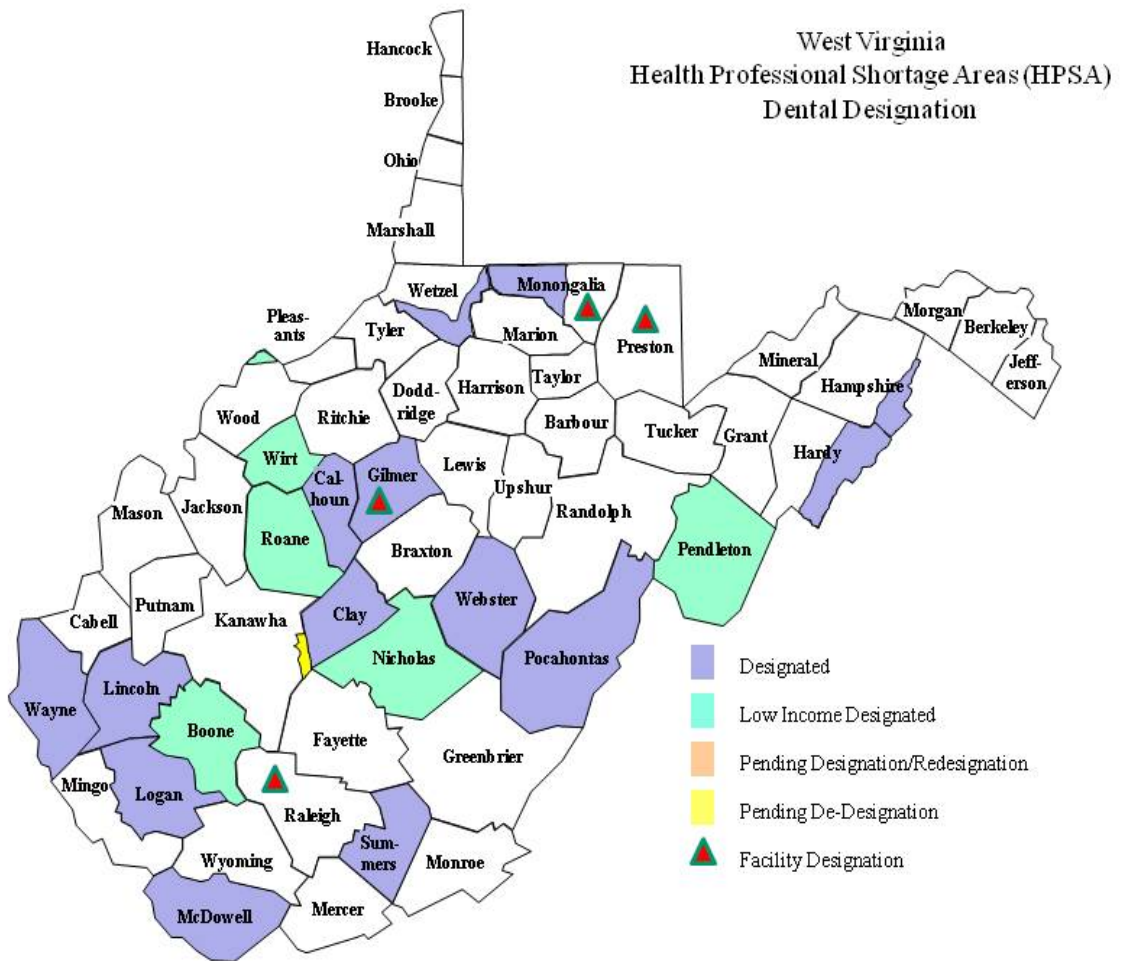
Figure 7



Appalachian Regional Commission/Benedum Foundation

Based on recent data the following map depicts the WV Health Professional Shortage Areas for Dental Care, January 2010.

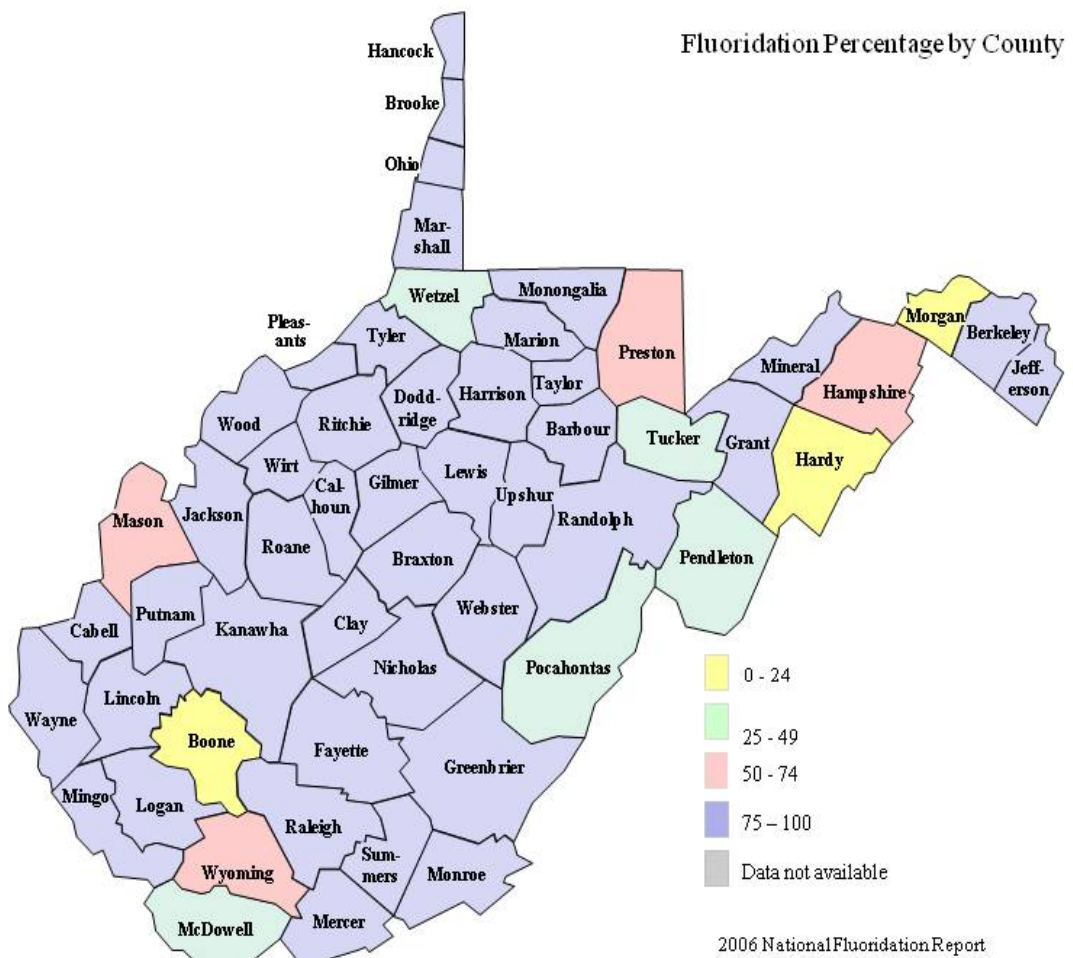
Figure 8



Fluoridation

Sixty-five years ago, on January 25, 1945, the city of Grand Rapids, Michigan, added fluoride to its municipal water system and community water fluoridation began. Since that day, this simple, safe, and inexpensive public health intervention has contributed to a remarkable decline in tooth decay in the United States, with each generation enjoying better oral health than the previous generation. Currently, 69.8% of the water serving households in West Virginia is fluoridated. See the following map from the 2006 National Fluoridation Report:

Figure 9



Smoking and oral health

Besides the link between tobacco and heart disease, stroke, emphysema, and cancer (especially lung and throat cancers), smoking leads to the following oral health consequences:

- Bad breath.
- Tooth discoloration.
- Inflammation of the salivary gland openings on the roof of the mouth.
- Increased build up of plaque and tartar on the teeth.
- Increased loss of bone within the jaw.
- Increased risk of leukoplakia, white patches inside the mouth.
- Increased risk of developing gum disease, a leading cause of tooth loss.
- Delayed healing process following tooth extraction, periodontal treatment, or oral surgery.
- Lower success rate of dental implant procedures.
- Increased risk of developing oral cancer.

Table 10
Percentage Cigarette Smoking Among Adults Age 18 Years and Older

Information	<i>Percentages</i>
<u>TOTAL Percent of Adults</u>	26.5%
<u>RACE</u>	
Black	37.2%
White	26.1%
Other	35.9%
<u>GENDER</u>	
Female	27.0%
Male	26.0%

2008 WV BRFSS

Table 11

Percentage of Students in High School (9th – 12th grade) Who Smoked Cigarettes or Who Used Chewing Tobacco or Snuff on One or More Occasions Over the Past 30 Days

Information	<i>Percentages</i>	
	Cigarettes	Chews
<u>TOTAL Percent of HS Students</u>	27.6%	14.8%
<u>RACE</u>		
White	27.7%	15.2%
Black	*	*
Other	*	*
<u>GENDER</u>		
Female	28.0%	2.2%
Male	27.4%	27.0%

2007 WV YRB

*less than 100 students in this subgroup

West Virginia ranks first in the nation for smoking, health outcomes in a number of areas, show this as a major problem. Despite attempts to educate residents and encourage quitting, the rate has fluctuated very little in the last several years.

Need for oral health surveillance

Monitoring the status of oral disease in the State’s population is essential for setting achievable goals and objectives as well as for planning, implementing, and evaluating public health programs. Currently, West Virginia does not have a surveillance system in place.

Using the definition of surveillance in public health (the ongoing and systematic collection, analysis, dissemination, and interpretation of outcome-specific data), the data shows there is an impending need to develop new techniques to build up surveillance systems for oral diseases. Surveillance is the process which provides data, and puts the information into action. The data disseminated by a public health surveillance system can be used for immediate public health action, program planning and evaluation, and formulating research hypotheses. It can also be a valuable tool with identifying resources.

Surveillance systems would provide information necessary for public health decision-making. A comprehensive public health surveillance system would routinely collect data on health outcomes, risk factors and intervention strategies for the whole population or representative samples of the population. Having a surveillance system in place would help identify key oral health indicators that could assist the oral health program in finding usable, creditable data. At the state and local level, an integrated system of data collection would be an evolving process as new techniques would be developed in response to new demands. It also is important for illustrating the burden of oral disease and for gaining support and funding for the state oral health program. To develop a state oral health surveillance system, oral health programs must assess the currently available assets, such as data sources that already include an oral health component, other state resources and capacity that can be used to augment those of the oral health program.

Under the leadership of the Association of State and Territorial Dental Directors (ASTDD), and in collaboration with the Centers for Disease and Control Prevention (CDC), the National Oral Health Surveillance System (NOHSS) was developed to help public health programs monitor the burden of oral disease, use of the oral health care delivery system, and monitor the status of community water fluoridation on both state and national levels. The National Oral Health Surveillance System is a web-based query system (<http://www.cdc.gov/nohss/>) which is available to the public and includes indicators for oral health, information on state dental programs, and links to important oral health information. Below are some examples and benefits of a surveillance system:

- A plan for collecting, analyzing, and disseminating data.
- Surveillance of oral diseases using key oral health indicators (e.g., state fluoridation status, caries experience, or decayed, missing, and filled teeth) are standard approaches for comparability across states.
- Monitor water fluoridation data monthly using a system such as the Association of State and Territorial Dental Directors/Centers for Disease and Control Prevention Water Fluoridation Reporting System.
- Update data at periodic, specific intervals.
- Current data and indicators consistent with other reporting systems; e.g., the National Oral Health Surveillance and Water Fluoridation Reporting System (WFRS).

Summary of Community Oral Health Forums and Development of State Oral Health Plan

The Office of Maternal, Child, and Family Health partnered with Marshall University and other key stakeholders in oral health to develop a statewide comprehensive oral health plan in accordance with CDC recommendations. Marshall University applied for and received a grant from the Claude Worthington Benedum Foundation in the amount of \$45,000 to provide logistical support and technical assistance to the Office of Maternal, Child and Family Health in the planning process. The West Virginia Department of Health and Human Resources, Oral

Health Advisory Board took the lead in this effort and met every other month to discuss progress and working in assigned work groups provided updates from the regional forums.

Key components in the development of the state oral health plan will be the input and involvement received from all key stakeholders, as well as data collected from regional community town hall meetings. The community meetings were held in nine different locations in the State with over 285 participants in attendance. The regional meetings were held on the dates and locations listed below:

1. July 17th, at the Greenbrier, White Sulphur Springs, West Virginia (in conjunction with the West Virginia Dental Association)
2. August 6th, at Oglebay Resort and Conference Center State Park, Wheeling, West Virginia (in conjunction with the WVPCA)
3. September 11th, at the Blennerhassett Historic Hotel, Parkersburg, West Virginia (in conjunction with the Mid-Ohio Valley Oral Health Task Force)
4. September 24th, at Stonewall Resort and Conference Center, Roanoke, West Virginia (in conjunction with the West Virginia Public Health Dental Section)
5. September 28th, at Boone County Armory, Madison, West Virginia (in conjunction with REV Up Madison, All About Health, The Wellness Council of West Virginia & The Robert Wood Johnson Foundation)
6. October 22nd, at West Virginia University Health Sciences Center, Morgantown, West Virginia (in conjunction with the West Virginia University School of Dentistry)
7. October 22nd, Glade Springs Resort (in conjunction with WVPCA)
8. November 13th, Charleston, West Virginia, Charleston Area Medical Center (in conjunction with Growing Healthy Children Conference)
9. November 20th, at Martinsburg, West Virginia (in conjunction with the WV Healthy Smiles Partnership of the Eastern Panhandle)

Following a presentation on the need for a current oral health plan by representatives from the West Virginia Department of Health and Human Resources, Oral Health Advisory Board, the audience was given opportunity to provide input and feedback from their respected regions. At the conclusion of the meeting, a West Virginia State Oral Health Plan Survey was provided to collect information and identify key priorities that need to be addressed to improve the status of oral health in West Virginia. Participants were asked to rank (1-9) various issues with the most important barriers ranked first.

The following table is a summary of the information collected from the regional community meeting participants:

Table 12.
Survey Results from Regional Community Meeting Participants.

Ranking of Priorities	Priorities at a glance
1	Disease Treatment and Prevention – <i>Direct services, prevention vs. restorative, cost and, by whom, etc.</i>
2	Public Education and Outreach – <i>Social marketing of the importance of good oral health.</i>
3	Funding/ Reimbursement – <i>Insurance coverage, Medicaid, PEIA as well as federal funding opportunities.</i>
4	School Based Education and Service Delivery – <i>Services provided at a school or school related site.</i>
5	Oral Health Promotion across the lifespan – <i>Looking at oral health from perinatal, children and adults through seniors.</i>
6	Workforce – <i>Scope of practice, shortage of dental providers, recruitment and retention.</i>
7	Water Fluoridation and Fluoride Programs – <i>Water treatment plants, fluoride rinse programs, etc.</i>
8	Data Collection and Surveillance – <i>On going monitoring of the status of oral health in West Virginia.</i>
9	Burden of Disease and Documentation – <i>An encompassing report on the current status of oral health in West Virginia.</i>

WV School Health TA & Evaluation, Marshall University

Final approval of the State Oral Health Plan will be given by the West Virginia Department of Health and Human Resources Oral Health Advisory Board. Delivery of the plan will be provided during the 2010/2011 Legislative Session and will allow West Virginia to seek additional federal funding and support for the Oral Health Program.

Objectives and Strategies

Mission: The mission of the West Virginia Oral Health Program is to improve the oral health status of West Virginia by providing a structured approach to meeting the oral health needs of everyone in the state.

Objective One: The West Virginia Oral Health Program will strengthen West Virginia’s state-level infrastructure and capacity to improve the oral health of its citizens.

Strategy 1:1 – The West Virginia Oral Health Program will secure adequate funding to support staff expansion of oral health efforts and implementation of the oral health plan, including at a minimum:

- A full-time oral health director to administer and supervise all dental health programs within the West Virginia Bureau for Public Health.
- Recommend assessing the feasibility of hiring a full-time dentist with a public health degree and or experience as the oral health director, in accordance with West Virginia State Personnel Policies (<http://www.state.wv.us/admin/personnel/jobs/default.htm>).
- A part time epidemiologist to develop, implement and monitor an oral health surveillance system
- Adequate staff to support and ensure implementation of the state plan, such as a fluoridation specialist and epidemiologist.

Stakeholders: West Virginia Bureau for Public Health, West Virginia Department of Health and Human Resources Oral Health Advisory Board

Timeline: Years One-Two

Strategy 1:2 – The West Virginia Oral Health Program will establish and maintain a state-based oral health surveillance system to assess needs and monitor progress in improving oral health systems in accordance with Centers for Disease Control and Prevention recommendations.

Stakeholders: West Virginia Bureau for Public Health, West Virginia Department of Health and Human Resources Oral Health Advisory Board

Timeline: Years One-Two

Strategy 1:3 – The West Virginia Oral Health Program will complete a “burden of disease” report on oral health disease in West Virginia, which includes a study of all payers regarding the

current costs of emergency room visits incurred for dental problems to determine if expenses can be reduced through more appropriate utilization of expanded coverage, and preventive programs.

***Stakeholders:** West Virginia Bureau for Public Health, Payers, West Virginia Children's Health Insurance Program, West Virginia Bureau for Medical Services, West Virginia Public Employees Insurance Agency, West Virginia Insurance Commission*

***Timeline:** Year One*

Strategy 1:4 - The West Virginia Oral Health Program will develop and sustain a statewide coalition of stakeholders in both public and private sectors invested in reducing oral health disease. The oral health coalition will:

- Advocate and support program and policy improvements.
- Encourage coordination and communication among stakeholders.
- Increase public awareness and understanding of the importance of oral health.

***Stakeholders:** West Virginia Department of Health and Human Resources Oral Health Advisory Board, West Virginia Bureau for Public Health, West Virginia Healthy Kids and Families Coalition, West Virginia School Based Health Assembly; state associations; all with an interest*

***Timeline:** Years One-Three*

Objective Two: The West Virginia Oral Health Program will develop a financing strategy for oral health services and implementation of the state plan recommendations.

Strategy 2:1 - The West Virginia Oral Health Program will develop a budget and assess costs and revenues needed to support expansion of the West Virginia Bureau for Public Health Oral Health Program and fund expansion of oral health services.

***Stakeholders:** West Virginia Bureau for Public Health, West Virginia Department of Health and Human Resources Oral Health Advisory Board*

***Timeline:** Years One-Two*

Strategy 2:2 - The West Virginia Oral Health Program will analyze feasibility and develop a strategy for approval of a one cent increase in the tax on soft drinks. Such a tax would also encourage West Virginians to make healthier drink choices.

Stakeholders: *West Virginia Dental Association, West Virginia Dental Hygiene Association, West Virginia Council of Churches, West Virginia Growing Healthy Children, West Virginia Oral Health Coalition once established, Other Public Interest Groups*

Timeline: *Years One-Five*

Strategy 2:3 - The West Virginia Oral Health Program will establish recommendations for systematic and ongoing monitoring/evaluation of reimbursement, and incremental/phasing in of increases in West Virginia Medicaid and West Virginia Children’s Health Insurance Program reimbursement for dental services to 25% of the American Dental Association Mid Atlantic scale; giving priority to increased reimbursement for oral health surgery (i.e., shift away from emergency) and other services critical to increasing access.

Stakeholders: *West Virginia Department of Health and Human Resources Oral Health Advisory Board, West Virginia Dental Association, West Virginia Dental Hygiene Association, West Virginia Bureau for Medical Services, West Virginia Dental Assistants, West Virginia Children’s Health Insurance Program*

Timeline: *Years One-Five*

Strategy 2:4 - The West Virginia Oral Health Program will develop a plan to phase in expansion of coverage for preventative and basic restorative services for children, adults, and pregnant women under the West Virginia Children’s Health Insurance Program, West Virginia Public Employees Insurance Agency, and West Virginia Medicaid.

Stakeholders: *West Virginia Children’s Health Insurance Program, West Virginia Public Employees Insurance Agency, West Virginia Bureau for Medical Services, West Virginia Department of Health and Human Resources Oral Health Advisory Board, West Virginia Dental Association, West Virginia Dental Hygiene Association; West Virginia Dental Assistants*

Timeline: *Years One-Five*

Strategy 2:5 - The West Virginia Oral Health Program will explore feasibility of a public/private partnership for development of an affordable, basic dental plan for adults that includes features such as an employer-based “pool” that is supplemented by state funds and includes individual contributions.

Stakeholders: *West Virginia Department of Health and Human Resources, West Virginia Bureau for Medical Services, West Virginia Oral Health Coalition once established, West Virginia Dental Hygiene Association*

Timeline: *Years One-Five*

Objective Three: The West Virginia Oral Health Program will promote oral health across the lifespan.

Strategy 3:1 - The West Virginia Oral Health Program will identify funding to implement a statewide oral health public awareness campaign with consistent messages targeted to specific high risk groups including pregnant women, minorities, parents of young children, nursing home staff, and health professionals

Stakeholders: West Virginia Department of Health and Human Resources Oral Health Advisory Board, West Virginia Perinatal Partnership, West Virginia Right from the Start, West Virginia Head Start, West Virginia Women, Infants and Children, West Virginia Higher Education Policy Commission

Timeline: Years One-Two

Strategy 3:2 - The West Virginia Oral Health Program will collaborate with all health professionals to increase oral health awareness across the lifespan, to incorporate lifelong dental care into current medical protocols, and to promote dental care as part of an integral part of a medical home

Stakeholders: West Virginia Department of Health and Human Resources Oral Health Advisory Board, West Virginia Oral Health Coalition once established, West Virginia Higher Education Policy Commission, West Virginia University School of Dentistry

Timeline: Years One-Two

Objective Four: The West Virginia Oral Health Program will strengthen and improve the dental health workforce.

Strategy 4:1 - The West Virginia Oral Health Program will form a task force to study the following:

- The existing capacity and distribution of the oral health workforce to ensure oral health needs are met.
- How to extend or expand workforce capacity and productivity to address oral health in health care shortage areas.
- Ensure a sufficient workforce pool to meet oral health care needs.

Stakeholders: West Virginia Department of Health and Human Resources Oral Health Advisory Board, West Virginia Higher Education Policy Commission, West Virginia University School of Dentistry, West Virginia Dental Association, West Virginia Dental

Hygiene Association, West Virginia Dental Assistants, West Virginia Primary Care Association, Division of Primary Care, Division of Recruitment and Retention

Timeline: *Years One-Two*

Strategy 4: 2 - The West Virginia Oral Health Program will develop a plan to address unequal distribution and shortage of dentists in rural areas including the following:

- Establish a uniform system for assessing oral health workforce capacity as one component of the oral health surveillance system.
- Assure capacity for schools of dentistry and dental hygiene to recruit and retain faculty to provide state of the art teaching and research opportunities.
- Recruitment and retention of dentists and dental hygienists:
 - A West Virginia loan repayment program and a *tax credit for service program* for dentists and dental hygienists who agree to practice in underserved areas. Providers would agree to see West Virginia Medicaid and West Virginia Children’s Health Insurance Program patients at a specified minimal level (e.g. 50%) or regardless of the ability to pay, which includes Temporary Assistance for Needy Families and pre-employment programs.
 - Maximize loan repayment options as they relate to the National Health Service Corps and the Recruitment Retention Community Project.
- Need for continuing health education training programs for health care providers, school educators, and extension specialists

Stakeholders: *West Virginia Department of Health and Human Resources Oral Health Advisory Board, West Virginia University School of Dentistry, West Virginia Higher Education Policy Commission, West Virginia Schools of Dental Hygiene, West Virginia Dental Assistants, West Virginia Dental Association, West Virginia Primary Care Association, Division of Recruitment and Retention*

Timeline: *Years One-Two*

Objective Five: The West Virginia Oral Health Program will invest in community prevention.

Strategy 5:1 - The West Virginia Oral Health Program will develop and implement a statewide plan for increasing the number of public water systems with fluoridated water

***Stakeholders:** West Virginia Department of Health and Human Resources Oral Health Advisory Board, West Virginia Bureau for Public Health, West Virginia Water Quality Division, West Virginia County Health Departments*

***Timeline:** Years One-Five*

Strategy 5:2 - The West Virginia Oral Health Program will develop a preventative oral health program for all West Virginians that involve a broad spectrum of health care professionals.

***Stakeholders:** West Virginia Dental Association, West Virginia Dental Hygiene Association, West Virginia Dental Assistants, West Virginia Bureau for Public Health, West Virginia Chapter of American Academy of Pediatrics*

***Timeline:** Years One-Five*

Strategy 5:3 - The West Virginia Oral Health Program will define protocol and develop educational components and training opportunities for pediatricians and family practitioners to replicate successful and proven preventive oral health programs such as fluoride varnish, promoting good oral health activities and linkage to dental homes.

***Stakeholders:** West Virginia Dental Association, West Virginia Chapter of American Academy of Pediatrics, West Virginia Chapter of Academy of Family Physicians*

***Timeline:** Years One-Five*

Strategy 5:4 - The West Virginia Oral Health Program will work with the West Virginia Department of Education to analyze, evaluate and redefine the role of the state's Oral Health Educators to maximize their effectiveness as community oral health prevention specialists.

***Stakeholders:** West Virginia Bureau for Public Health, West Virginia Department of Education, West Virginia Department of Health and Human Resources Oral Health Advisory Board*

***Timeline:** Years One-Two*

Strategy 5:5 - The West Virginia Oral Health Program will encourage local boards of health to implement a dental health component in their program plans and provide outreach activities to inform the public of the type and availability of oral health services

***Stakeholders:** West Virginia Bureau for Public Health, West Virginia Department of Health and Human Resources Oral Health Advisory Board*

***Timeline:** Years One-Two*

Strategy 5:6 - The West Virginia Oral Health Program will support and collaborate with oral cancer educational programs in the state to:

- Study risk factors that lead to oral cancer.
- Improve accessibility of screening to detect oral cancer.
- Stress high risk behaviors, signs, and symptoms of oral cancer in oral health education presentations.

***Stakeholders:** West Virginia Division of Tobacco Prevention, West Virginia Bureau for Public Health*

***Timeline:** Years One-Three*

Objective Six: The West Virginia Oral Health Program will strengthen the role of West Virginia’s schools in promoting the oral health of students.

Strategy 6:1 - The West Virginia Oral Health Program will improve oral health knowledge among students through teacher trainings about oral health as an integral part of overall health by:

- Teacher trainings about oral health as a key component of overall health.
- Assessment and monitoring of learning outcomes regarding oral health.

***Stakeholders:** West Virginia Department of Education, West Virginia Bureau for Public Health, West Virginia Oral Health Educators, West Virginia Department of Health and Human Resources Oral Health Advisory Board*

***Timeline:** Years One-Five*

Strategy 6:2 - The West Virginia Oral Health Program will incorporate strategies to increase parent instruction and involvement in oral health education.

***Stakeholders:** West Virginia Department of Education, West Virginia Department of Health and Human Resources Oral Health Advisory Board, West Virginia Dental Association, West Virginia Dental Hygiene Association, West Virginia Bureau for Public Health*

***Timeline:** Years One-Five*

Strategy 6:3 - The West Virginia Oral Health Program will promote and support expansion and improvement in school-based oral health programs including the following:

- Fluoride rinse programs.
- Sealant programs.
- Protective mouthguard requirement for all West Virginia Secondary Schools Activity Commission sports.

***Stakeholders:** West Virginia Department of Education, West Department of Health and Human Resources Oral Health Advisory Board, West Virginia Dental Association, West Virginia Dental Hygiene Association, West Virginia Bureau for Public Health*

***Timeline:** Years One-Five*

Strategy 6:4 - The West Virginia Oral Health Program will evaluate and make recommendations for policies requiring dental examinations prior to school entry collaborating with the Governor's Kids First initiative to ensure a dental component.

***Stakeholders:** West Virginia Department of Education, West Virginia Dental Association, West Virginia Dental Hygiene Association, West Virginia Oral Health Committee once established, West Virginia Bureau for Public Health*

***Timeline:** Years One-Five*

Objective Seven: The West Virginia Oral Health Program will maintain, evaluate, and monitor state plan implementation.

Strategy 7:1 - The West Virginia Oral Health Program will establish a process to implement the state plan, including defining roles and responsibilities and local agencies for planning and evaluation, coordination and accountability.

***Stakeholders:** West Virginia Department of Health and Human Resources Oral Health Advisory Board*

***Timeframe:** Years One-Five*

Strategy 7:2 - The West Virginia Oral Health Program will report progress on a regular basis to Select Committee D on Oral Health.

***Stakeholders:** West Virginia Bureau for Public Health*

***Timeline:** Years One-Five*

Strategy 7:3 - The West Virginia Oral Health Program will establish a broad based coalition focused on oral health improvement for all West Virginian's across the lifespan.

***Stakeholders:** West Virginia Bureau for Public Health, West Virginia Department of Health and Human Resources Oral Health Advisory Board*

***Timeframe:** Years One-Five*

ACKNOWLEDGEMENTS

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