

Dental Cuts Bite Children, Cost All Californians: The Case for Investing in School-Based Preventive Services

California's policymakers have recently slashed the budgets of children's health and dental programs. To prevent a significant increase in costly and damaging dental disease among the state's children, leaders must quickly and creatively invest in preventive dental services. Successful programs and funding models from other states can point the way.

Three cuts during the 2009-10 state budget cycle were particularly harmful to children's dental health.

1. Funding for the California Children's Dental Disease Prevention Program (CCDDPP) was suspended indefinitely. The CCDDPP provided preventive dental services (such as fluoride rinse and dental sealants) and education to approximately 300,000 preschool and elementary school children annually.

2. The Healthy Families Program (HFP), California's Children's Health Insurance Program (CHIP) providing comprehensive health, dental and vision coverage to nearly one million children, was vastly underfunded, precipitating a freeze on new enrollment starting July 17, 2009. Although the funding gap eventually was filled temporarily, nearly 90,000 wait-listed children went without coverage, and progress to insure more children was thwarted.

3. Dental benefits for most adults in the Medi-Cal program were largely eliminated on July 1, 2009, making children's access to basic oral health services more difficult, because many providers rely on the reimbursement received from treating adults to remain financially solvent and children are more likely to receive dental services if their parents use them.

The implications of these budget cuts are deep and wide, jeopardizing the oral health and overall health and well-being of children in the state. The cuts will further degrade an oral health system that already fails to meet the needs of too many California children.



Facts About California Children’s Oral Health

- Approximately two-thirds, or 6.3 million, of California children suffer needlessly from poor oral health by the time they reach third grade.¹
- California ranks second to last in the nation on children’s oral health status, besting only Texas. In a recent National Survey of Children’s Health, California children’s oral health ranked among the lowest of all the states. Only 63.5% of California parents rate their children’s teeth in “excellent” or “very good” condition compared to the national average of 70.7%.²
- Low-income children are at higher risk of suffering from dental disease. California children who participate in the Free and Reduced Lunch Program have a higher prevalence of decay than those who do not participate in the program (72% vs. 52%). They also experience more untreated decay (33% vs. 22%) and urgent dental care needs (5.5% vs. 2.5%).³
- Over 500,000 California children missed one or more school days as a result of oral health problems (not routine check-ups) in 2007.⁴ Untreated oral health problems impact children’s ability to thrive in school.
- The Surgeon General’s Report on Oral Health cited tooth decay as the most common chronic childhood disease in the nation, above asthma and hay fever.⁵
- For every dollar spent on preventive dental services for children, \$8 to \$50 is saved in restorative and emergency treatments later in life.⁶
- Poor oral health is linked to other health problems, such as cardiovascular disease, diabetes and, for women, premature births. The foundations for adult oral health are laid early in life.⁷
- Treating oral health problems is far more difficult and costly in emergency rooms. For example, a comprehensive oral exam averages \$60 in a dentist’s office compared to an emergency room visit, which averages \$172, or hospitalization, which averages \$5,044.⁸
- Death from untreated dental disease is rare, but not unheard of. In 2007, 12-year-old Deamonte Driver of Maryland and 6-year-old Alexander Callender of Mississippi died due to the spread of bacteria from untreated dental infections.⁹

While California’s current economic crisis may make cuts to programs and services seem inevitable, the consequences and effects of these cuts are far-reaching and more serious than many realize. Cuts to dental programs that provide basic preventive services to California’s at-risk children not only are

unwise, but fiscally irresponsible given the high return on the small investment such programs yield. In order to help the state recover from fiscal calamity, state leaders must invest wisely in cost-effective measures, such as school-based preventive dental programs, to better address the oral health needs of children and the economic well being of California. Investing in prevention creates cost savings down the road and helps keep children out of pain, in school and on the right track.

Budget Cuts Recklessly Gamble with Children’s Dental Health

Cuts to dental services for children couldn’t come at a worse time. Not only are more children losing health and dental insurance, but the traditional public programs that were once available to help meet children’s oral health needs have either been eliminated or severely crippled.

Children’s Dental Disease Prevention Program Suspended

In fiscal year 2009-10, the California Children’s Dental Disease Prevention Program (CCDDPP) was slated to receive just \$2.94 million in state funds (0.0035% of the total state budget of \$84.5 billion).¹⁰ When policymakers decided to eliminate that funding, California’s spending on school-based oral health promotion for its 10 million children dropped to zero.

The California Department of Public Health’s Office of Oral Health ran the CCDDPP, operating 33 programs in 31 counties across the state and providing critical dental services to preschool and elementary school children for nearly thirty years. In 2007-08 alone, the CCDDPP served 1,112 schools and 307, 880 children, many of whom shared their new skills and knowledge at home with family members.¹¹

Case Study

First-Grader’s Dental Problems Hindered His Interest in Reading

A teacher in San Diego County began to notice drastic changes in a bright, energetic, first grade boy who had been eager to learn to read. The boy seemed to be losing weight, didn’t want to play at recess and began to lose hair. The teacher also noticed he wasn’t eating lunch or the snacks she brought for her students. The teacher talked with the school nurse, and medical testing was arranged. Although the tests came back normal, it was clear something was wrong.

The teacher’s class participated in the school’s CCDDPP, and when the program educator gave a brushing lesson, the boy refused to put a toothbrush near his mouth. After the teacher shared her concerns about the boy, the educator decided to check his teeth. She found his molars were so decayed they were even with the gum line. They also contained multiple abscesses. The CCDDPP educator and school nurse found a dentist who provided free treatment. After the dental work was completed, the boy’s personality reemerged, and he learned to read.

Services included:

- Fluoride supplementation (varnish, weekly mouth rinse or daily tablet);
- Dental sealants;
- Plaque control;
- Oral health education;
- An active oral health advisory committee;
- Dental screenings (optional).¹²

The CCDDPP served the children at highest risk of suffering from preventable dental disease, but could have served far more children if it had been adequately funded.¹³ Nearly 2.5 million children were enrolled in qualifying Free and Reduced Lunch schools (serving the lowest-income areas) in counties with CCDDPP sites in November 2008. CCDDPP services were able to reach only 12% of eligible students.¹⁴

Local programs were reimbursed only up to \$10 per child by the state. To help supplement state dollars, some local programs were able to leverage additional funding, such as grants or county general funds, to draw down federal Medicaid Administrative Activities matching funds. In 2006, these programs leveraged an additional \$6.80 for every \$10 provided by the state.¹⁵

After the Kindergarten Oral Health Requirement (AB 1433) was passed in 2006, many CCDDPP coordinators were instrumental in providing implementation assistance to schools and County Offices of Education. The legislation required that children have a dental check-up by the end of their first year in public school.¹⁶ Although screenings are not a required component of CCDDPP, many coordinators were able to assist schools and families by providing the oral health screenings for the kindergartners.

Despite the successes of the CCDDPP, including a “Best Practice” recognition from the Association of State and Territorial Dental Directors,¹⁷ state funding for the program was eliminated. Without state funding, maintaining the local programs is virtually impossible. As a result, the loss of the program comes with steep consequences. The Office of Oral Health recently received a federal Health Resources and Services Administration grant that will allow dental school students to provide some preventive and restorative services for children at primary care clinics.¹⁸ However, these funds are insufficient to save the extensive infrastructure of the CCDDPP.

Budget Cuts and Recession Stall Progress on Children's Health Coverage

In these tough financial times, parents are losing jobs and employer-sponsored dependent coverage, and the state is also drastically cutting programs that provide low-cost health and dental coverage for children. UC Berkeley's Center for Labor Research and Education estimates that 300,000 California children lost employer-based health coverage between November 2007 and February 2009.¹⁹

The federal government has recognized the importance of investing in children's health insurance programs, providing states with new opportunities and incentives to expand CHIP. California is the only state that made program cuts, which directly impact children, despite federal incentives and the historic need for affordable coverage through the Healthy Families Program (HFP).²⁰ HFP received a devastating financial blow, as half its total budget (\$194 million) was cut by the Legislature and Governor. As a result, the nearly one million children enrolled in the program faced the possibility of disenrollment at their annual renewal date. In addition, a freeze on new enrollment, which began on July 17, 2009, created a waiting list of nearly 90,000 children, who were unable to enroll in HFP's comprehensive health and dental coverage. Although the funding gap was later filled temporarily, long-term funding is still in question.

Moreover, the funding fix for HFP may further jeopardize the oral health access of enrollees. As part of the deal to fill the shortfall, new HFP subscribers will be required to enroll in a dental managed care plan instead of a preferred provider plan for the first two years.²¹ There is evidence that managed care enrollees' access and utilization of dental services is lower than fee-for-service enrollees.²²

Many California families are unable to pay, out-of-pocket, the full cost of their children's dental visits. As a result, they are forced to delay their children's dental care, causing oral health problems to worsen and become more painful and costly to treat. Emergency room visits for oral health problems also increase when parents find themselves unable to afford regular preventive dental services for their children.

A study conducted on Children's Health Initiatives (CHIs) in Los Angeles, San Mateo and Santa Clara counties found that these low-cost insurance programs significantly increased children's access to and use of preventive dental services. The study also revealed that CHI enrollment drastically reduced children's unmet oral health needs.²³ Unfortunately, nearly half of all California counties do not have a local CHI program, and many CHIs are experiencing financial difficulties and have waiting lists for new enrollment.²⁴

Adult Denti-Cal Program Largely Eliminated, Putting Children’s Access at Risk

On July 1, 2009, Denti-Cal benefits were largely eliminated for most adults, leaving approximately three million adult Medi-Cal enrollees with very limited dental coverage and without access to comprehensive dental services.²⁵ As a result of this cut, children face increased difficulty in accessing providers to serve and treat their basic oral health needs, because many providers rely on the reimbursement they receive from treating adults to remain financially solvent. Also, a study of Medicaid families found that, when parents do not make at least one dental visit annually, their children are 13 times less likely to visit a dentist that same year.²⁶ The cut compounds the shortage in dental providers willing to treat Denti-Cal children, because the low reimbursement rates often do not cover the cost of providing the service. Through volume and good management, certain providers, such as community clinics and health centers, were able to sustain a practice that served mostly Denti-Cal patients. Some of these providers, however, may be unable to sustain their practice due to loss of revenue from treating adults in Denti-Cal. Community clinics estimate they stand to lose \$56.5 million in revenue, causing some to shutter their entire dental programs.²⁷ At least two dental clinics in Northern California have already closed.²⁸

California already ranks near-last in the nation in children’s oral health status. The virtual elimination of adult Denti-Cal creates yet another barrier to children’s oral health care in the state.

The Importance of Children’s Preventive Dental Services

Historically, California’s oral health system has inadequately addressed the needs of children for a variety of reasons, including low reimbursement rates for providers in public programs, decreasing numbers of providers willing to accept public coverage and inadequate overall funding invested in children’s oral health programs. As a result of these shortcomings, millions of children in California suffer needlessly from oral health problems and pain that could have been prevented.

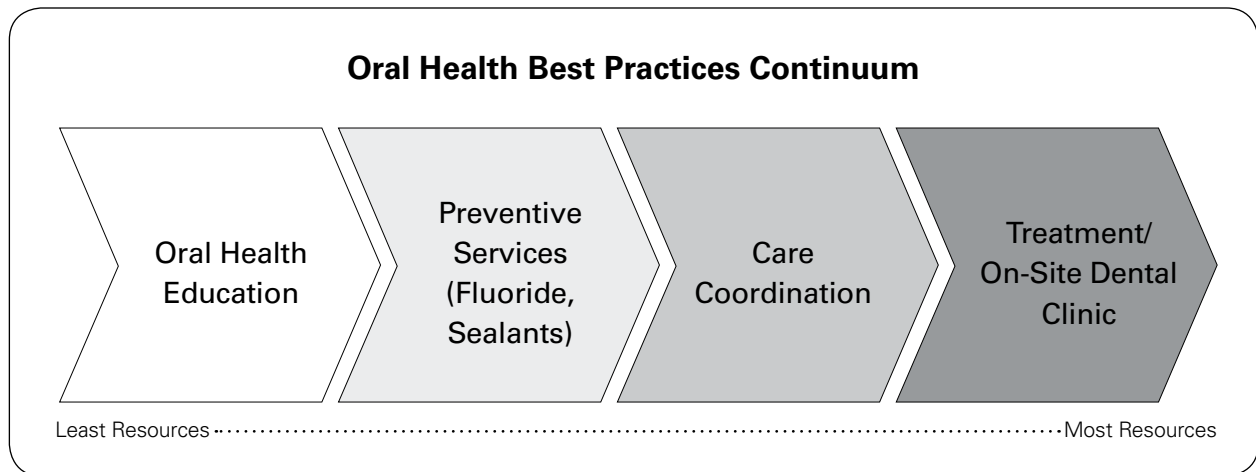
Children need healthy teeth to eat properly, communicate and smile with confidence. Children in pain have difficulty paying attention in school—if they manage to go to school at all. In 2006, it was reported that more than 50% of California children have already experienced tooth decay; 28% have untreated tooth decay; and 19% have extensive decay.²⁹ Untreated tooth decay can become more severe and lead to costly emergency room care. Severe dental disease in

children can require general anesthesia and several days of hospitalization, often costing over \$20,000.³⁰

Moreover, untreated oral health problems can cost the ultimate price: life. In 2007, Deamonte Driver, a 12-year-old boy from Maryland, died due to delayed care of an untreated tooth abscess. Another child, 6-year-old Alexander Callender of Mississippi, died when bacteria from a tooth infection spread throughout his body.³¹

School-Based Dental Disease Prevention Programs: A Continuum of Best Practices from Other States

Many states have realized the wisdom of investing in school-based oral health programs to provide a basic minimum of preventive services for children most at risk of dental disease. One commonality among many state school-based prevention programs is their targeting of children in schools with a high percentage of students enrolled in the Free and Reduced Lunch Program. Such targeting helps ensure the programs reach the children most at risk of oral health problems, as well as children with the least financial access to private dental care.



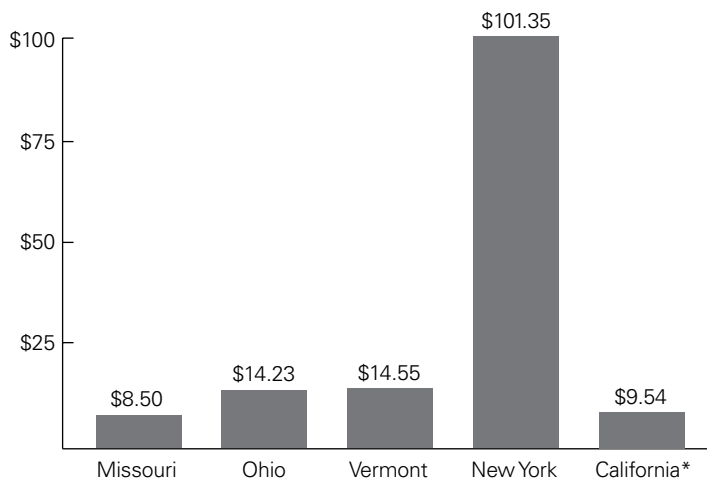
Unlike California, most states continue to provide state funding necessary to maintain programs, while others have devised unique and creative ways to keep programs intact.

Missouri, Ohio, Vermont and New York are just a few of the many states that have implemented strong school-based prevention programs. A number of communities in California have developed successful models for improving children’s oral health. What the state lacks is a comprehensive and coordinated

program, so every California child has the same opportunity to grow up free from dental disease.

School-based oral health promotion best practices can be envisioned along a continuum, from least to greatest investment of resources: (1) oral health education, (2) preventive services (such as fluoride varnish and dental sealants), (3) care coordination and (4) treatment at a school-based or -linked dental clinic. Examples of the components of the continuum and what California can learn from them are described below.

School-Based Oral Health Promotion Program Examples
(Estimated Amount Spent per Pupil)



*California's program has since been defunded.

Sources: Personal communication with Robin Perez Miller, Vermont Department of Health, Office of Oral Health; Missouri Department of Health and Senior Services, Oral Health Program; Ohio Department of Public Health, "The Ohio Department of Health School-Based Dental Sealant Program," submission to the Association of State and Territorial Dental Directors, 2002; David Appel, MD, "Health Center at Bronx High School Adds Dental Program to Further Serve Low-Income Minority Students," Robert Wood Johnson Foundation, 2007.

Missouri's Oral Health Education: Delivering Online & In-Person Resources

Missouri teaches children about the importance of oral health care, using online resources and in-school performances to reach children where they are. The online curriculum is available to children in English, Spanish and Native American versions of age-appropriate presentations for children in the classroom. Missouri's Department of Health and Senior Services Oral Health Program also offers a downloadable coloring book and list of videos that schools can request for free. A valuable county-by-county guide to dental services in the school's area is also available online.³²

Delta Dental's "Land of Smiles" stage performance for children in kindergarten through third grade

teaches about oral health and features Delta Dental's Tooth Wizard, Panda and PlaqueMan characters. In 2008, the show visited over 320 schools and educated over 70,000 children. Each year, the characters also appear at the St. Louis Zoo.³³

Funding: Many school-based educational resources are available through partnerships with private organizations like Dental Delta, which provides the “Land of Smiles” performances and accompanying materials free of charge.

Lessons for California: Although the CCDDPP did include an oral health education component, online education resources were not provided through a central state website. Only some local programs provided online information and educational material via county websites in the form of basic oral health care instruction, preventive tips and coloring pages for children. California could look to adopt Missouri’s innovative approach to online oral health education for children to help them absorb information in creative ways, which may be more conducive to learning and retention. Some oral health experts, however, advocate focusing limited dollars on preventive services, restorative treatments and care coordination instead of education. California should weigh available evidence about the effectiveness of educational programs.

Further, special attention to improving the usability of Denti-Cal’s online provider list would assist California school staff and families in connecting children to a regular source of dental care. For example, usability testing with focus groups of school staff could generate recommendations for improvement of the current provider list available through the InsureKidsNow.gov federal website.³⁴

Ohio’s Preventive Services: Providing Dental Sealants & Fluoride Rinse

Ohio uses its limited funding earmarked for children’s oral health care to specifically target high-risk children, who attend schools where 40% or more of the students qualify for the Free and Reduced Lunch Program and/or schools in districts whose median family income is less than 150% of the federal poverty level.

Ohio’s dental sealant program provides sealants in schools, using portable dental equipment. (A sealant is a hard, thin plastic covering applied to the chewing surface of a tooth to prevent decay.) The program specifically targets second- and sixth-graders. Dentists examine students to identify the teeth that need to be sealed, and then dental hygienist or dental assistant teams place the sealants on the children’s teeth. Third- and seventh-grade students who received sealants in the prior year are also screened to ensure the integrity of the sealants and place sealants on newly erupted teeth. Children are also assessed for other dental problems, and parents are notified if follow-up care is needed.³⁵

The Ohio Department of Health also supports fluoride mouth rinse programs, targeted primarily at elementary schools in communities without adequate fluoride in the water and those in very low-income areas.³⁶ Every participating school has a coordinator who oversees the fluoride rinse program, keeps records and delivers mouth rinse to classrooms. Teachers generally supervise the rinsing activity, and dental hygienists conduct site visits, monitor the program and provide guidance to schools.

Funding: Most of the preventive programs receive grant funding from the Ohio Department of Health and are operated by local health departments, educational institutions or nonprofit organizations, with a few locally-funded programs operated by local health departments, educational institutions or nonprofit organizations. The cost for the sealant program was between \$49 and \$56 per child in 2008, while the supplies for the fluoride rinse program cost less than \$0.25 per child per year.³⁷

Lessons for California: California provided dental sealants and fluoride treatments to children up to sixth grade through the CCDDPP, as outlined earlier; however, the number of children served through the program was limited due to inadequate funding. All children in need were not provided sealants because the programs simply didn't have the financial resources to meet the need. Ohio's program provides sealants and inexpensive fluoride treatment to children through seventh grade, and also re-checks previously placed sealants. California could look to expand the population of children receiving these services and monitor prior dental work. Additionally, the state could look to fund these preventive services through a federal Maternal & Child Health Block Grant, and explore how to better use Medi-Cal's, and potentially Healthy Families', provider reimbursement to fund preventive dental services.

Vermont's Tooth Tutor Program: Coordinating Care

The goal of Vermont's Tooth Tutor program is to ensure children have access to regular preventive and restorative care in a dental office – or, in other words, the child is linked to a “dental home.” To meet this goal, schools contract with local dental hygienists, “Tooth Tutors,” and the Vermont Department of Health provides schools with a list of Tooth Tutors they can contract with. Currently, 45 Tooth Tutors work in 122 schools, helping children access needed oral health care.³⁸

The Tooth Tutor Program began as a pilot project in 1997 and has expanded greatly since then. Now, half of all elementary schools and all Head Start programs participate in the Tooth Tutor Program.³⁹

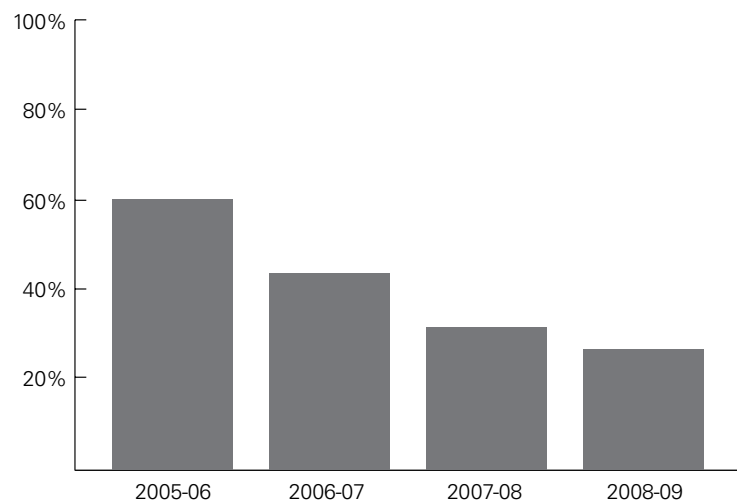
Case Study

The Extensive Reach of a Preventive Program in Rural California

A CCDDPP administered through Del Norte Clinics serves three rural northern California counties: Butte, Glenn and Tehama. Administrators, health aides, school nurses and teachers were all utilized to deliver a variety of preventive services to students in over 35 elementary and middle schools.

Evidence-based services, such as dental screenings, sealants, fluoride administration and education were delivered to the student population. Over 1,000 kindergarten students in these rural counties benefited from kindergarten oral health screenings through AB 1433, 300 of whom received additional referrals due to signs of tooth decay and infections. Together, nearly 6,000 children were screened for dental problems, and 1,664 had infections that were subsequently treated. Last year alone, the program assisted schools and parents in accessing care for 238 children who needed emergency dental care. Over 11,000 children across the three counties received hands-on education and practice in skills they will need for a lifetime of good oral health care.

Percentage of Students Who Needed Treatment for Infections After Preventive Program Inception in 2005 (One School District Served by Del Norte Clinics)



The responsibilities of Tooth Tutors include:

- Acting as a liaison between families and community dentists;
- Helping the school nurse update dental information in each child's school health file, allowing children who lack access to regular dental care to be identified;
- Providing free dental screening to children upon request;

- Presenting dental health education in classrooms;
- Helping families troubleshoot barriers to dental care, such as transportation, literacy, finances or lack of information;
- Working with dental offices to educate them about the barriers faced by families, and helping families keep children’s dental appointments.

Funding: Most Tooth Tutors are funded through the Medicaid Early and Periodic Screening, Diagnosis, and Treatment program, while others are funded through grants and foundations. The state received nearly \$1 million from the Robert Wood Johnson Foundation’s State Action for Oral Health Access initiative, allowing the program to grow significantly.⁴⁰

Lessons for California: As California moves forward, care coordination must be a required component of any program. Some CCDDPP sites did include this service, but it was not a mandated component. Care coordination is a vital piece that ensures children receive necessary dental care. Additionally, like Vermont, California should ensure that children in Head Start and other preschool programs are linked to school-based prevention programs. The chance to prevent costly dental disease is better when at-risk children are reached earlier in life.

New York’s School-Based Dental Centers: Offering Comprehensive Care

Only 8.2% of 1,700 school-based health centers in the country provide comprehensive dental care, and only 13% have dental services at all.⁴¹ The Montefiore School Health Program, operated by the Montefiore Medical Center, is the largest school-based health program of its kind in the nation, serving more than 20,000 children at 16 sites throughout the Bronx. Comprehensive dental services, including education, screening, preventive services, restorative dental care and referral to specialty care, are provided at three sites, including DeWitt Clinton High School. Project staff worked with administrators and teachers to foster acceptance of the dental program, and helped school staff understand the connection between oral health and success in school.⁴²

Funding: Initial funding for the DeWitt program (\$225,000 over 3 years) came from the Robert Wood Johnson Foundation, through a national Center for Health and Health Care in Schools project. Partnership with local medical centers or universities is one strategy to help school-based health centers provide comprehensive, cost-effective dental care.

Lessons for California: Comprehensive school-based dental programs are the gold standard for providing children access to oral health care, since their

convenient location allows children to access services without missing school (and parents from missing work). California has 23 school-based or school-linked health centers that provide dental services.⁴³ Some, like the Young and Healthy program in Pasadena, are successful models that California should expand.⁴⁴

Missouri, Ohio, Vermont and New York are but a few examples of states that have effective strategies to combat children's dental disease in schools. California policymakers should integrate the best practices of these and other states' school-based oral health promotion programs and focus on cost-effective, evidence-based services for children most at risk for dental disease.

Recommendations: How California Can Move Forward

The oral health needs of California's children cannot continue to be ignored, as it is more costly to repair dental disease than to prevent it. California must find creative ways to address the growing problem of poor oral health in children. To do this, policymakers should revisit and reverse the decision to virtually eliminate any state role in helping children access preventive dental services through schools.

- California should reinvest in school-based dental disease prevention by building on the strengths and infrastructure of the now-defunct CCDDPP. Adequate per-child funding levels would help ensure the school-based program reaches more children and uses state-of-the-art dental preventive techniques.
- California children's oral health stakeholders (including oral health researchers, policymakers, dental professionals, dental and education advocates, consumers and others) should convene to devise policy recommendations for a new, school-based preventive dental program. Special consideration should be given to:
 - o Educating school staff on the basics of oral health;
 - o Ensuring the program has adequate oversight and evaluations to measure effectiveness;
 - o Coordinating with existing successful strategies to reach younger children (such as First 5 and WIC oral health promotion efforts), and exploring links with child care and preschool sites;
 - o Investigating the feasibility of social marketing campaigns as a catalyst for behavioral change related to oral health.

- The stakeholder group should determine if other states’ best practices for school-based oral health education, prevention, care coordination or comprehensive school clinics could be adopted in California.
- California should investigate funding models from other states’ programs that do not rely exclusively on general fund dollars, such as oral health grants, federal funding and other creative partnerships. The state should explore how to better use Medi-Cal’s, and potentially Healthy Families’, provider reimbursement to fund preventive dental services. Additionally, California should maximize all opportunities to leverage federal funds, such as those available through Medicaid Administrative Activities or a Maternal & Child Health Block Grant. Although states are awaiting further details, the American Recovery and Reinvestment Act of 2009 or a federal health care reform deal may provide oral health prevention and wellness funding that could potentially be used for school-based services. Additionally, soda fees and specialty license plate fees are two methods used by other states to fund oral health care for children.
- California policymakers and stakeholders should investigate the possibility of allowing mid-level practitioners to provide dental care for children in order to expand the available dental workforce, especially in rural or underserved areas. In addition, California should fully develop the potential of AB 667 (Block), which explicitly allows laypersons to apply fluoride varnish in school and public health settings as of January 1, 2010.⁴⁵

Endnotes

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Children Now is a nonpartisan, nonprofit organization dedicated to giving all children the opportunity to reach their full potential. Children Now is pleased to be a part of the Oral Health Access Council, a multilateral, nonpartisan effort directed toward improving the oral health status of the state's traditionally underserved and vulnerable populations.