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California's State Oral Health Infrastructure: Opportunities for Improvement and Funding

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ABSTRACT California has virtually no statewide dental public health infrastructure leaving the state without leadership, a surveillance program, an oral health plan, oral health promotion and disease prevention programs, and federal funding. Based on a literature review and interviews with 15 oral health officials nationally, the paper recommends hiring a state dental director with public health experience, developing a state oral health plan, and seeking federal and private funding to support an office of oral health.

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California has virtually no statewide dental public health infrastructure. The state has no dental director, no oral health plan, no statewide oral health surveillance system and no statewide prevention programs. Dental services for low-income adults are limited to emergency-type procedures and most children on Medi-Cal do not have regular dental visits. The lack of leadership within California's state government means the state forgoes necessary funding for oral health and preventive programs are not implemented.

This article is intended to review the dental public health infrastructure in California and other states, identify potential funding sources for oral health activities in California, and provide recommendations for policies to be adopted in California to ensure it has a viable infrastructure that can develop, support, fund, and coordinate oral health programs.

Methodology

This article is based on a literature review of documents relevant to state oral health infrastructure and funding, as well as semistructured key informant interviews conducted in 2010 with 15 experts on state oral health infrastructure including federal officials in Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC), seven state dental directors, a national oral health organization, and California stakeholders.

California's Oral Health Crisis

California's oral health programs have been decimated in recent years. In 2009, the Legislature eliminated all but emergency-related dental benefits for adults in the Medi-Cal program. Similarly, the Legislature "indefinitely suspended" funding for the California Children's Dental Disease Prevention Program (CCDDPP)

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that provided screening, oral health education, fluoride applications and sealants serving more than 300,000 school and preschool children in 32 counties.

- Fewer than one in five (19 percent) of California children aged 0-5 on Medi-Cal had a dental visit in 2007. Benefits have now been eliminated for nearly all adult services under Medi-Cal.[1]
- More than seven in 10 (71 percent) California children suffer from tooth decay by the time they reach the third grade.[2]
- Nationally, tooth decay is the most common chronic disease among children, five times more common than asthma.[3]
- Despite having 14 percent of the nation's dentists and 12 percent of the nation's population, California has 21 percent of the 4,230 federally designated dental health professional shortage areas.[4] These shortage areas are found throughout California, in both urban and rural areas.
- Fewer than six in 10 (59 percent) of California residents received fluoridated water as of 2008.[5]

While California is still under the national average for fluoridation, this is a major improvement over prior years. With the implementation of fluoridation in the San Diego area in 2011, an estimated 62 percent of Californians have fluoridated water.[6]

National Standards for State Oral Health Infrastructure

After years of analysis and refinement, the characteristics of efficient and effective state oral health infrastructures have been well-defined by national organizations, including the Association of State and Territorial Dental Directors (ASTDD) and the CDC. These guidelines provide an excellent roadmap of where California's oral health infrastructure should be and how to get there.

The 2000 ASTDD report, "Building Infrastructure and Capacity in State and Territorial Oral Health Programs," identifies elements that would build capacity for state oral health programs to achieve the Healthy People Oral Health Objectives.[7] The report specifies that a key infrastructure element is having leadership to address oral health problems, with a full-time state dental director and an adequately staffed oral health unit with competence to perform core public health functions.

DESPITE HAVING

14 percent of the nation's dentists and 12 percent of the nation's population, California has 21 percent of the 4,230 federally designated dental health professional shortage areas.

ASTDD further describes the role of a state oral health program as providing leadership and programming to improve oral health through the public health core functions of assessment, policy development, and assurance. The assessment role is fulfilled through a state-based oral health surveillance system. The policy development role is to provide leadership to address oral health problems with a full-time state dental director, developing a state oral health plan and promoting policies for better oral health and health systems. The assurance role is to provide communications and education to the public and policy-makers, build linkages with coalitions, committees and workgroups; coordinate and implement population-based prevention interventions; build community capacity to implement community-level interventions; develop health systems interventions to facilitate quality dental care services; and leverage resources to adequately fund public health functions.[8]

The CDC's Division of Oral Health has used ASTDD's expertise to establish national standards for its funding and technical assistance to help state health agencies develop and operate public health programs to improve oral health.

The CDC has developed a collection of tools for state health officials to plan, develop, implement and evaluate oral health programs that include health promotion and disease prevention.[9] Among other things, these resources include tools for developing a strong state program infrastructure to ensure successful oral health programs. How California infrastructure measures up to CDC's components is contained in **TABLE 1**.

The importance of state oral health infrastructure is endorsed by the Institute of Medicine in its recent report, "Improving Access to Oral Health Care for Vulnerable and Underserved Populations," where it recommended that the federal health care agencies "ensure that each state has the infrastructure and support necessary to perform core dental public health functions (e.g., assessment, policy development, and assurance)."[10]

California's State Oral Health Infrastructure

California Health and Safety Code Section 104750 requires the Department of Public Health to maintain a dental program whose role includes, but is not limited to:

1) Development of comprehensive dental health plans within the framework of the state plan for health to maximize utilization of all resources;

2) Provide the consultation necessary to coordinate federal, state, county, and city agency programs concerned with dental health;

3) Encourage, support, and augment the efforts of city and county health departments in the implementation of a dental health component in their program plans;

4) Provide evaluation of these programs in terms of preventive services; and

5) Provide consultation and program information to the health professions, health professional educational institutions, and volunteer agencies.

Section 104755 mandates that the dental program be administered by a licensed dentist.

Compliance with the legislative requirements of sections 104750 and 104755 appears to be minimal. There has been no state dental director for the dental program for 15 years. The oral health unit's "chief" and sole staff person is not a dental professional. There is no state oral health plan nor is there any evaluation of programs. Moreover, there is no capacity to provide consultation and support to local health jurisdictions, health professions, or educational institutions. There is also a lack of ability to apply for and manage federal and other grant programs to support oral health.

Available Federal Funding and Support

Most states with comprehensive oral health programs rely heavily on federal funding to support their programs and use minimal state funds. The two major sources of state oral health funding from the federal government are the CDC and HRSA, which includes Maternal and Child Health block grant funds. In addition, some states finance their oral health programs using matching federal Medicaid (Medi-Cal) funds.

The national health reform legislation —

TABLE 1

How California Measures up Against CDC's Elements for State Oral Health Infrastructure

1. Leadership capacity CDC recommends a full-time dental director who is an oral health professional with training in public health and other professional staff.	No dental director with dental or public health experience, or minimum staff capacity
2. Data collection and surveillance CDC recommends the development of a dedicated oral health surveillance system which measures key oral health indicators (e.g., fluoridation status, caries experience, and complete tooth loss) using standard and comparable approaches.	Needs assessment last done in 2004-2005 for children by Center for Oral Health and funded by private and federal funders. System for California Oral Health Reporting (SCOHR) was developed by the San Joaquin County Office of Education to compile statewide data for AB 1433 – the kindergarten dental check-up law implemented in 2007.
3. State oral health plan CDC recommends a state oral health plan to include specific objectives related to oral health promotion, disease prevention and control, and specific risk factors.	None
4. Statewide oral health coalition CDC recommends the formation of an active, independent statewide oral health coalition with diverse representation and help formulate plans, guide program activities, and seek funding.	Oral Health Access Coalition (OHAC) is administered by Center for Oral Health and California Primary Care Association
5. Policy development CDC recommends that the state oral health program conduct a periodic assessment of laws, regulations, administrative policies, and systems-level strategies that have the potential to reduce oral diseases.	None from the State Department of Public Health
6. Evaluation of oral health programs CDC recommends expert assistance in planning and conducting an evaluation of the state oral health program can assist in determining if its goals and objectives are being met.	No overall evaluation plan
7. Community water fluoridation program CDC establishes guidelines for a state water fluoridation program to promote, implement, and maintain consistency of community water fluoridation efforts.	There are state water fluoridation consultants paid for with federal grants, as well as a fluoridation council administered by the California Dental Association Foundation.
8. School-based dental sealant program CDC recommends school-based dental sealant programs that are highly effective programs to prevent tooth decay in children targeting vulnerable populations that may be at greater risk of developing decay and have difficulty in accessing care.	Suspended indefinitely

the Patient Protection and Affordable Care Act (PPACA) — significantly expands federal funding for oral health. It expands CDC's funding for cooperative agreements for oral health infrastructure from the current 16 states to all states. It also expands funding for school-based sealant programs to all 50 states. These funds must be requested by a state, and only state agencies can be the recipient of these funds. These funds have been authorized but not as yet appropriated.

In addition to its funding through cooperative agreements, the CDC has also provided staff directly to states. These staff members from the public health service have been assigned to act as dental directors or subject matter experts for a period of time. Often, these staff assist the state in applying for additional federal funding to further develop programs and infrastructure.

Lessons From the States

A number of lessons were learned from interviews with state and federal officials that are relevant to California.

Key Elements in a State Program Structure

Leadership, Leadership, Leadership

The most critical element for an effective state oral health office identified by the dental directors was leadership. It is essential to have a person with an oral health background and public health orientation, and a vision for how to improve the oral health status in a state.

Strong Support From Department and Policy-makers

While it is essential to have a strong director in the oral health office, it is also important to have an understanding and support of leadership in the state health department, as well those in policy-making roles in the executive and legislative branches.

Visibility in State Agency Is Critical

A state oral health office must have sufficient visibility in the state health department to be considered a core component of the health infrastructure and department funding. Access to department heads and policy-makers is key to developing and implementing strategic agendas.

State Legislation Establishing an Office of Oral Health and Director Position Is Helpful but Not Essential

Many states have codified the role of the office of oral health and minimum qualifications of a dental director. However, some states with strong oral health offices do not have any legislative mandate for an office of oral health. Having a legislative mandate however, does not guarantee an effective office.

Key Development Lessons

Models and Infrastructure Support Are Readily Available From CDC and ASTDD

Some states have developed their oral health offices from scratch with the support of the CDC and ASTDD. These agencies have national standards for offices of oral health, tools and roadmaps for developing a strong infrastructure, funding, and technical assistance. California could greatly benefit from the support and guidance of national organizations to develop a strong office of oral health and effective oral health programs.

Not All Work Needs to Be Done by the State

The state dental directors emphasized that the state oral health office does not generally operate large programs, but rather partners with other agencies in the public and private sectors to implement programs. The basic roles of the state office of oral health are assessment, policy-making, and assurance rather than actual administration of programs.

Doing Something Is Better Than Doing Nothing

It took a number of years for the successful programs to develop. Rather than trying to plan and implement all components at one time, the directors developed the programs over time. Having a strong leader, developing an oral health plan in partnership with statewide coalitions, and accessing available funding are important first steps.

Funding Lessons

The First Reason for Not Getting a Grant Is Not Applying

The federal government has had funds available to support state oral health infrastructures for many years, but California has not applied. California should begin applying now for CDC infrastructure funds and strongly consider applying for additional HRSA funds. If the state does not currently have the capacity to prepare a grant application, a number of partners can assist in the effort.

State Funding Is Not Key to an Effective Oral Health Program

A number of the state dental directors noted that they receive little or no state funding for their programs. When state funds are allocated, they are primarily used for core infrastructure, with other funds being leveraged for programs. According to a national survey of state oral health funding conducted by the Pew Center on the States, 94 percent of funding for California's Oral Health Unit is state funding compared to many states where less than half of the funds come from the state. The current state funding is for one staff person to provide administrative support for the few contracts and grants that the state has.

Creativity and Flexibility in Grant Seeking Is Essential

Effective dental directors bring together funding from various sources to support their offices and ensure that effective statewide oral health programs are in place. Many states rely heavily on Maternal and Child Health block grant funds and some use Medicaid matching funds to support their offices. State programs have also partnered with philanthropies to develop programs focused on vulnerable populations.

Partnerships

Coalitions and Partnerships at the Statewide and Local Levels, Both in and out of Government, Are Critical

State oral health programs rely heavily on coalitions and partnerships to develop and implement their strategies. These partners include associations of dental professionals, educational institutions, dental plans, local health jurisdictions, health advocates and policy-makers. It is also important for oral health offices to develop strong relationships with other state departments such as Medicaid, Title V Maternal and Child Health programs, professional licensing, and education.

Build on Successes and Existing Programs and Resources

California is fortunate to have a wide array of programs and funders such as dental schools, engaged dental and dental hygienist associations, First 5 commissions, oral health advocacy groups, school-based programs, a statewide oral health access coalition, and private philanthropies, and some local health department programs. Building on these programs and drawing from their experiences and resources will support the success of an oral health program.

Build Partnership and "Champion" Strategies

Developing and strengthening programs requires strategies for building partnerships and champions. Having strong champions for oral health on local and statewide levels is critical to garnering support from policy-makers and funding sources. The nurturing of these partnerships is an essential part of successful programs.

State Oral Health Plan and Evaluation

If You Don't Know Where You Are Going, You Won't Know if You Are Getting There

Having a comprehensive state oral health plan will guide program development, grant seeking, and funding allocation. It also enables evaluation to measure the success of programs and strategies. A comprehensive plan will also include strategies to ensure the public is informed about oral health policy and the direction the state is going.

Data Can Drive Work and Highlight Successes

Building a surveillance system that monitors and reports the burden of oral disease with periodic updates allows oral health programs to track progress on key indicators, develop new strategies and highlight its successes to policy-makers and the public. Having accurate data is critical to decision-making and garnering support from partners and policy-makers.

Recommendations for California for Building a State Oral Health Infrastructure

Based on the interviews with state and national oral health infrastructure experts and review of relevant literature, the following recommendations are made for California:

Hire a Director With Dental Public Health Experience

California needs to hire a dental director with public health experience. There has been no dental director in California for more than 15 years despite the mandate of Health and Safety Code Section 104755. The dental director needs to have the full support of the department and policy-makers in developing and implementing an oral health agenda in California. Without the leadership of a dental director and strong support from policy-makers, it will not be possible to develop an effective oral health program in California and address the growing oral health needs of the population.

HAVING STRONG CHAMPIONS for oral health on local and statewide levels is critical to garnering support from policy-makers and funding sources.

Develop an Oral Health Plan Building on What Exists Throughout California

California has no state oral health plan to guide policy-makers, state departments, local health jurisdictions, advocacy organizations, professional associations, funders, educational institutions and community-based programs. Nor are there effective assessment tools to measure progress in meeting oral health goals from those programs in effect at the local level.

The oral health plan needs to be built upon what exists, identify needs and gaps in programs and develop strategies to fill the gaps. It must be developed through a collaborative, inclusive process that brings together California's stakeholders and draws upon in-state and out-of-state expertise.

Work With Existing Stakeholders and Programs

California has a myriad of statewide and local oral health coalitions and programs. There are also national experts at California's dental educational institutions and professional associations. The state's oral health unit should maximize their inclusion in strategy development, program implementation, and evaluation. The role of the office should be to ensure adequate funding for programs, but not necessarily to operate the programs itself.

Seek Federal and Private Funding to Support Programs

California has not taken advantage of the millions of dollars of federal assistance that is provided to states for oral health infrastructure. With the expansion of federal assistance for oral health, California needs to immediately investigate federal funding to support an office of oral health and the development and implementation of an oral health plan. In addition, California should look to the experience of other states that have used other available funds such as MCH block grants, Medicaid (Medi-Cal) funds, and philanthropy to support their offices of oral health.

Develop New Childhood Prevention Programs

With the "indefinite suspension" of the decades-old school-based Children's Dental Disease Prevention Program, California has an opportunity to reinvigorate a school-based oral health program using the latest strategies and interventions, as well as seek new funding streams. Promising practices, such as using preschools, Head Start, and WIC sites to link very young children and their parents to dental care and education, should be investigated. Services for older children through school-based preventive and treatment programs can also be expanded.

Conclusion

California should not continue to ignore its responsibility and the legislative mandate to have coordinated strategies to improve the oral health of its residents. The first step for overcoming the neglect of the past decades is to appoint a dental director to provide leadership in mapping out proven health improvement strategies. Far smaller states than California have received substantial federal support to fund this effort. The national health reform legislation makes additional oral health funds available to states, but states need to have an adequate infrastructure to apply for and administer these funds. Without leadership and support, Californians will continue to suffer with preventable dental disease, while other states receive federal funds to improve the health of their populations. ■■■■

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