OPTIMAL ORAL HEALTH FOR ALL RHODE ISLANDERS

Rhode Island Oral Health Plan, 2011–2016

RHODE ISLAND ORAL HEALTH COMMISSION • RHODE ISLAND DEPARTMENT OF HEALTH • WWW.HEALTH.RI.GOV • JANUARY 2011

TABLE OF CONTENTS

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January 2011

Dear Rhode Islanders,

The Rhode Island Oral Health Commission has been the foundation of many efforts to improve oral health in Rhode Island over the past decade. The members of the Commission represent private practitioners; safety net providers; organizations that serve children, adults and elders; educational institutions; state agencies; insurers; foundations; and many other oral health advocates. We thank them for their continued dedication to their work and their contributions to the Commission.

We also would like to thank the Rhode Island Department of Health for providing data, report-writing, and administrative support to this report and to the Commission's on-going work. The Commission's Steering Committee also has provided thoughtful guidance to the Commission, and we thank them for their leadership. Finally, we want to extend our deep appreciation to the Commission's Workgroup Chairs for stepping up to facilitate coordinated movement toward the Commission's goals.

The **Rhode Island Oral Health Plan, 2011-2016** lays out a blueprint for our work together in the following areas:

- Improving Access to Oral Healthcare
- Implementing Evidence-Based Oral Healthcare
- Preventing Oral Disease, Promoting Oral Health
- Maintaining the Dental Safety Net
- Sustaining the Oral Health Workforce
- Informing Oral Health Policy Decisions

We are proud of the Commission's accomplishments and look forward to continuing to work together to achieve our shared mission: Optimal oral health for all Rhode Islanders.

Sincerely,

Elizabeth H. Roberts
Lieutenant Governor
Permanent Co-Chair
Rhode Island Oral Health Commission

Jill K. Beckwith, MPH
Policy Analyst, Rhode Island KIDS COUNT
Elected Co-Chair
Rhode Island Oral Health Commission

Development of the Rhode Island Oral Health Plan, 2011–2016

RHODE ISLAND ORAL HEALTH COMMISSION

The Special Senate Commission to Study and Make Recommendations on Ways to Maintain and Expand Access to Quality Oral Health Care for All Rhode Island Residents was established in 2000 to provide a coordinated statewide effort toward achieving optimal oral health and access to dental services for all Rhode Islanders. This foundational group of stakeholders expanded as a coalition with the formal establishment of the Rhode Island Oral Health Commission in 2010.

MISSION

The mission of the Rhode Island Oral Health Commission is to provide leadership to:

- *Formulate and promote sound oral health policy;*
- *Increase awareness of oral health issues; and*
- *Assist in promotion of initiatives for the prevention and control of oral diseases.*

VISION

The vision of the Rhode Island Oral Health Commission is to promote life-long optimum oral health through:

- *Primary prevention at the family, community, and healthcare professional levels;*
- *Accessible, comprehensive, and culturally competent community-based oral healthcare provided via a variety of financing mechanisms;*
- *Educational opportunities throughout life that will allow individuals to make better decisions for their health; and*
- *Informed and compassionate policy decisions at all levels of government.*

Oral Health in America: A Report of the Surgeon General alerted Americans to the importance of oral health in their daily lives. The report led a broad national coalition of public and private organizations and individuals to generate *A National Call to Action to Promote Oral Health*, which aims to improve quality of life and eliminate disparities through the development of oral health plans at the state and community levels.

In response to the *National Call to Action*, and the formation of the Special Senate Commission to Study and Make Recommendations on Ways to Expand Access to Quality Oral Health Care for All Rhode Island Residents, Rhode Island has issued two five-year, statewide oral health plans since 2001. The Rhode Island Oral Health Commission, in collaboration with the Rhode Island Department of Health and numerous stakeholders, developed the **Rhode Island Oral Health Plan, 2011-2016** (the Plan) to provide leadership, solicit feedback, and promote progress toward common goals for improved oral health in Rhode Island. With the publication of the Plan, the Commission acknowledges the past accomplishments of its members and sets a five-year future-focused course.

Goals

Listed below, the Plan's six goals mirror those identified in previous state plans, allowing past work to inform strategic planning for the future. Progress in these areas will further efforts to improve oral health, reduce the burden of oral disease, and eliminate oral health disparities among all Rhode Island residents.

Goal #1: Improve Access to Oral Healthcare Services: Remove known barriers between people and oral health services;

Goal #2: Implement Evidence-Based Oral Healthcare: Effectively apply evidence-based science and best practices to improve oral health;

Goal #3: Prevent Oral Disease, Promote Oral Health: Develop a comprehensive oral disease prevention and health promotion system;

Goal #4: Maintain the Dental Safety Net: Assure a strong dental safety net infrastructure;

Goal #5: Sustain the Oral Health Workforce: Assure an adequate and effective oral health workforce in Rhode Island; and

Goal #6: Inform Oral Health Policy Decisions: Assure adequate and appropriate information is available for effective policy decisions.

The Plan's Logic Model (see page 37) showcases how these goal areas will help Rhode Island reach its desired outcomes for oral health. We welcome you to review the Plan in its entirety and adopt its goals as your goals over the next five years.

Recommendations and Objectives

The Rhode Island Oral Health Commission developed the Plan based on input from dedicated workgroups that recommended state-specific strategies for reaching each of the six goals. Recommendations are intended to guide individuals in a variety of settings and do not prescribe specific measurement strategies; however, partners are encouraged to identify methods for evaluating their work. Where possible, workgroups also identified specific, measurable, achievable, realistic, and time-bound (SMART) objectives and general strategies to support their recommendations. The Commission will continue to develop measurable objectives to enhance accountability, prioritize activities, and better evaluate its work in the years to come.

Potential Partners

To achieve the goals, recommendations, and objectives outlined in this plan, the Rhode Island Oral Health Commission has identified potential partners, which include but are not limited to:

AARP • Advocacy Groups • American Academy of Pediatric Dentistry • American College of Obstetricians & Gynecologists • Brown University • Care New England • Carelink/Wisdom Tooth • Child Birth Hospitals • Community College of Rhode Island • Community Organizations • Elected Officials • Federally Qualified Health Centers • General Assembly Champions • Johnson & Wales University • Lifespan • Local School Districts • Long Term Care Coordinating Council • Medical Assistance Managed Care Insurers • New England Colleges & Universities • New England Dental Schools • Office of the Health Insurance Commissioner • Oral Health Professional Volunteer Programs • Providence College • Public & Private Health Insurers • Rhode Island Academy of Family Physicians • Rhode Island Chamber of Commerce • Rhode Island Chapter of the American Academy of Pediatrics • Rhode Island College • Rhode Island Dental Assistants Association • Rhode Island Dental Association • Rhode Island Dental Hygienists' Association • Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals • Rhode Island Department of Education • Rhode Island Department of Health • Rhode Island Department of Human Services • Rhode Island Health Care Association • Rhode Island Health Center Association • Rhode Island Hospital, Samuels Sinclair Dental Center • Rhode Island Medical Society • Rhode Island Oral Health Commission • Rhode Island Prematurity Taskforce • Rhode Island Public Water Facilities • RIte Care Insurers • Salve Regina University • School-Based Dental Programs • St. Joseph Center for Health and Human Services Pediatric Dental Center • Tobacco Cessation Organizations • University of Rhode Island

The Burden and Disparity of Oral Diseases in Rhode Island

Good oral health is critical to an individual's overall health and well-being. Freedom from mouth and facial pain, tooth decay and tooth loss, oral and pharyngeal cancer, and other oral conditions helps people stay healthy at every stage of their lives. Poor oral health, on the other hand, can significantly diminish an individual's health status and quality of life. Immediate effects of oral diseases include pain, disability, and difficulty eating and speaking. Depending on the severity of the condition and whether treatment is received, oral diseases may lead to missed work and school, emergency room visits, and depression and self-esteem issues.

Oral health status has improved for many Rhode Islanders over the past decade, but oral diseases still cause pain and disability for adults and children each year. More importantly, the burden of oral diseases is distributed unevenly among different populations. Disparities in oral health status exist among minority racial/ethnic groups, people of low socioeconomic status, and those who are underinsured or uninsured. Beyond these demographic risk factors, special healthcare needs, diabetes, pregnancy, and age constitute additional risk factors for common oral diseases or for oral disease-related health complications.

ORAL DISEASES

Dental Caries (Tooth Decay)

Dental caries is the most common chronic disease of childhood, both nationally and in Rhode Island. Unchecked, dental caries can result in loss of tooth structure, inadequate tooth function, unsightly appearance, pain, infection, and tooth loss. The pain and disability caused by untreated dental caries may limit children's ability to focus and perform in the classroom, causing them to miss school days and fall behind their peers. Significant disparities exist in the incidence of dental caries and untreated decay among Rhode Island children from different racial/ethnic and socioeconomic backgrounds. For example, Rhode Island third graders who are Hispanic or who attend schools with high student enrollment in free and reduced school meal (FRSM) programs are more likely to experience dental caries than their peers (High FRSM: 58%; Hispanic: 54%; Black: 47%; White: 46%; Low FRSM: 42%).[1] Adults also are at risk for dental caries and can experience decay on the exposed crown portion of a tooth or on the root surfaces of teeth that are exposed as gums recede. About one in five Rhode Island adults age 35–44 years self-report tooth decay.[2]

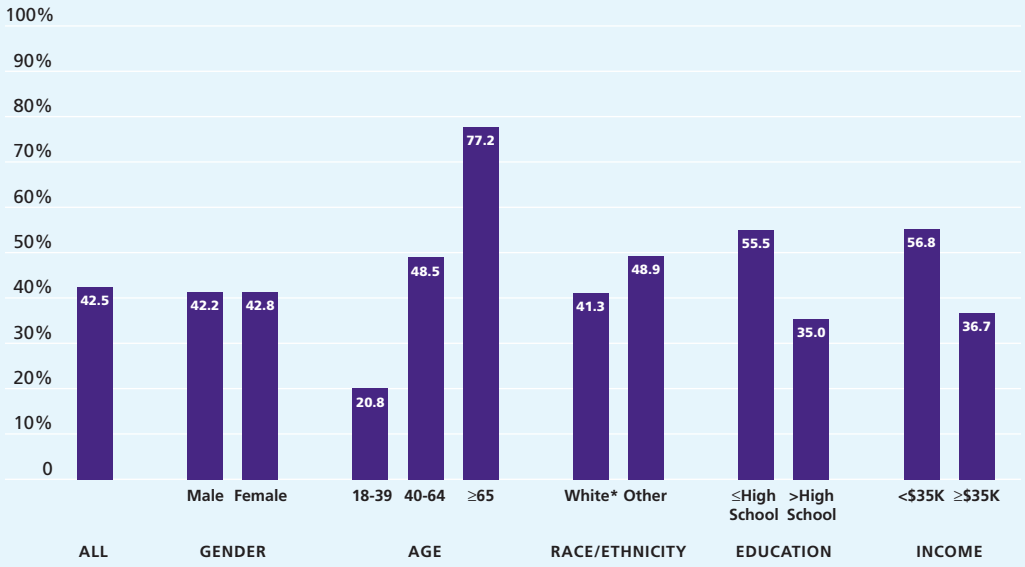
Tooth Loss

Tooth loss affects a person's ability to chew and speak and can interfere with social functioning. With adequate personal, professional, and population-based preventive practices, most adults keep their full set of teeth throughout their lives. Since 2000, statewide trends in tooth loss have improved among Rhode Island adults. The percentage of adults age 35–44 years who have never had a permanent tooth extracted due to dental caries or periodontal disease increased from 61% in 2000 to 69% in 2008. Compared to their counterparts, more adults of minority race, with less education, and/or with lower income report having one or more teeth lost due to dental caries and periodontal disease (Figure 1). The percentage of adults age 65–74 years with complete tooth loss (edentulism) decreased from 23% in 2000 to 13% in 2008.[2,3] For Rhode Island adults age 65+ years, edentulism is more common among those with lower education and income levels.[2]

FIGURE 1.

Rhode Island Adults (18+ Years) Who Have One or More Tooth Loss Due to Dental Caries or Periodontal Disease by Selected Characteristics

Source: Rhode Island Behavioral Risk Factor Surveillance System, 2008

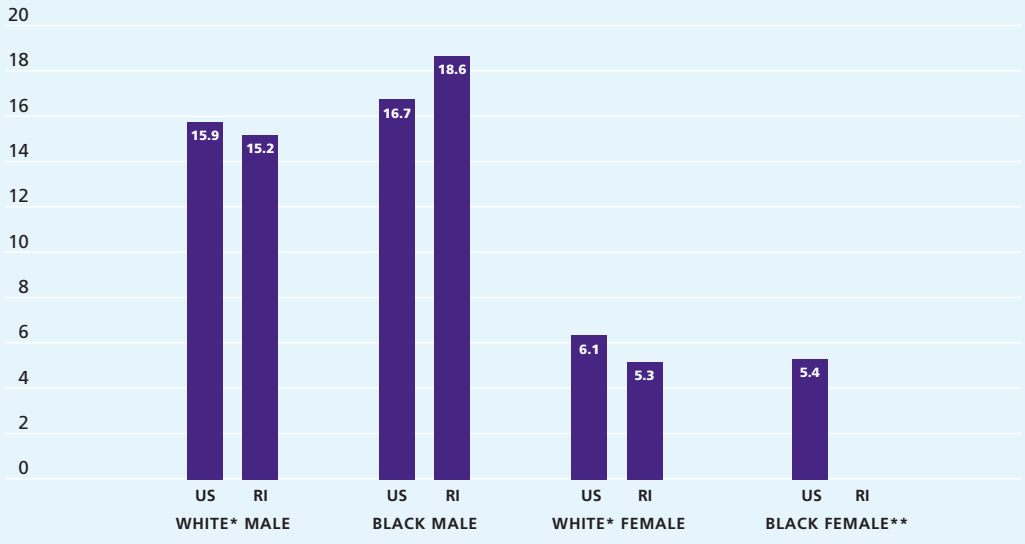


*Non-Hispanic White

FIGURE 2.

Incidence Rate of Oral and Pharyngeal Cancer in United States and Rhode Island by Race and Gender, 2002–2006

Source: CDC, National Program of Cancer Registries, United States Cancer Statistics for 2002–2006



*Non-Hispanic White

**Rhode Island black female rate is suppressed because fewer than 16 cases were reported.

Oral Cancer

Oral cancer includes cancer of the oral cavity or pharynx. Nationally, oral cancer is the sixth most common cancer in Black men and the eighth most common cancer in White men.[4] As seen in Figure 2, oral and pharyngeal cancers also are a significant issue in Rhode Island, particularly among men.

RISK FACTORS

Special Healthcare Needs

Studies show that people with special healthcare needs require treatment for tooth decay and periodontal disease at significantly higher rates than the general population, due in part to limited ability to understand and perform personal prevention practices or obtain needed services.[5]

Pregnancy Status

Oral health is an integral component of overall health and well-being for women and is particularly important prior to conception and during pregnancy. Recent evidence suggests that oral infections such as periodontitis during pregnancy may increase the risk of preterm or low birth weight deliveries.[6] In fact, pregnant women who have periodontal disease may be seven times more likely to have a baby that is born too early and too small.[7]

Diabetes

Diabetes is a recognized risk factor for severe and progressive periodontal disease, which can result in the destruction of tissues and supporting bone around teeth.[8] Despite their increased risks, data suggests that Rhode Island adults with diabetes access dental care at lower rates than their non-diabetic peers.[2]

Age

Older adults with poor general health may have difficulty maintaining adequate oral hygiene, visiting a dental office, or tolerating dental treatment due to limited dexterity, visual or mental acuteness, mobility, and stress tolerance. Oral cancers also occur primarily in adults age 65+ years and may sometimes go unrecognized and untreated in the absence of routine dental visits.

For a more comprehensive analysis of the burden of oral diseases in Rhode Island, please see the most recent publication of *The Burden of Oral Diseases in Rhode Island* at www.health.ri.gov/publications

Rhode Island Oral Health Plan 2011–2016: Goals & Recommendations

GOAL 1

IMPROVE ACCESS TO ORAL HEALTHCARE SERVICES: REMOVE KNOWN BARRIERS BETWEEN PEOPLE AND ORAL HEALTHCARE SERVICES.

Regular dental visits can prevent oral diseases from developing and decrease complex and costly treatments. However, the likelihood of visiting a dentist can be greatly determined by whether a person is enrolled in a dental insurance plan, the type of dental insurance provider they have, and the quality of their plan.

Children and adults with dental insurance have increased access to care. As shown in Figure 3, Rhode Islanders who do not have dental insurance are the least likely to have regular dental visits and are therefore at increased risk for poor oral health and oral disease. Across all ages, people who have public insurance are less likely to see a dentist than those who have private insurance. Despite making advances in access to oral healthcare for Rhode Island children over the past decade, more than 25% of Rhode Island adults age 18–64 years and more than half of adults age 65+ years still do not have any dental insurance coverage (Figure 4).

The extent of the coverage also poses problems for access to care. Medicare, for example, does not cover routine dental care and will only cover dental services for hospitalized elderly patients within very limited conditions. As a result, due to very limited or no dental insurance coverage, many adults age 65+ years incur out-of-pocket expenses for visits to a dental professional. This may lead to less frequent professional care at a time when periodic visits are needed most to facilitate diagnosis and treatment of oral diseases, including oral cancers. In 2008, 28% of Rhode Island adults 65+ years reported that their last dental visit was over one year ago, and among those 76% did not have dental insurance coverage. Comparatively, only 21% of Rhode Island adults age 18-64 years reported that their last dental visit was over one year ago, and only 50% of those did not have dental insurance.[2,3]

Limited coverage also poses a risk to pregnant women and their babies. Although all states are required to offer dental services for children in Medicaid, dental coverage for pregnant women is optional. However, studies have shown that if pregnant women are at risk for oral disease, their children will be, too.[9,10] By maintaining the pregnancy-specific dental benefit for women enrolled in RIte Care (Rhode Island's Medicaid managed care program), Rhode Island can continue to ensure that pregnant women maintain dental coverage.

Going forward, the state must continue to identify and remove the barriers that keep all populations, especially those with limited or no dental insurance coverage and those at higher risk for oral disease, from accessing needed oral healthcare services.

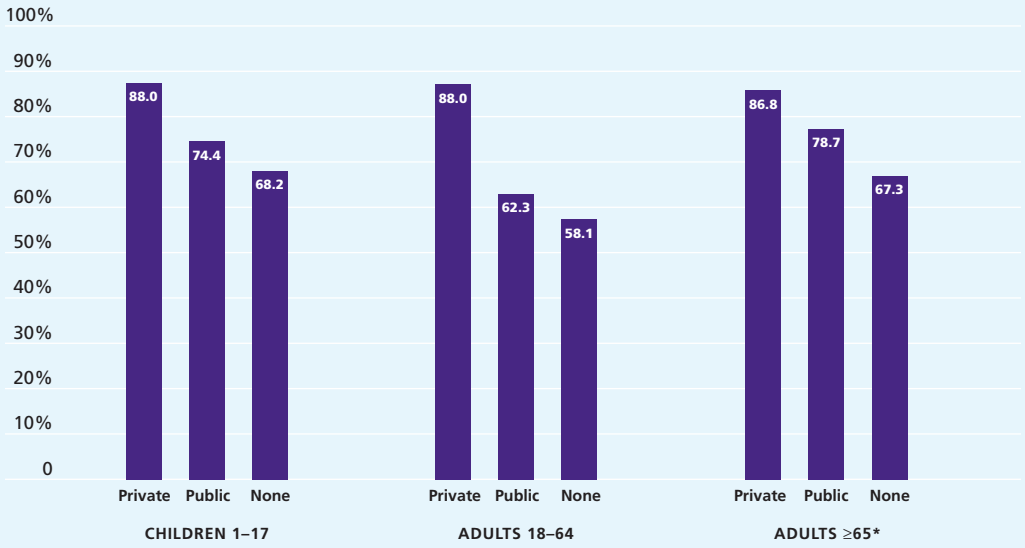
WHAT WE HAVE DONE

Rhode Island has expanded access to oral healthcare services for many Rhode Island children over the past decade through its RIte Smiles program. Launched in 2006, RIte Smiles is a nationally recognized dental benefits management program that serves young children enrolled

FIGURE 3.

Rhode Island Children and Adults Who Visited a Dentist or Dental Clinic in the Past 12 Months by Dental Insurance Type

Source: Rhode Island Behavioral Risk Factor Surveillance System, 2008

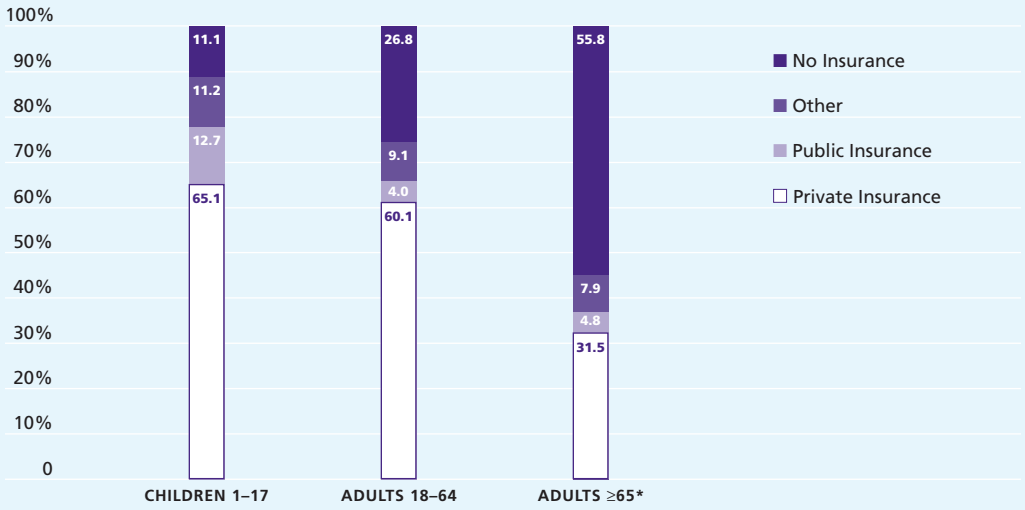


*Does not include nursing home or long-term care facility residents.

FIGURE 4.

Rhode Islanders with Dental Insurance that Pays for Routine Dental Care, 2008

Source: Rhode Island Behavioral Risk Factor Surveillance System, 2008



Definitions: Public Insurance includes RIte Smiles, RIte Care, and Medicare; Other includes coverage under Military, Veterans, or other unspecified insurance.

*Does not include nursing home or long-term care facility residents.

in Medicaid. RIte Smiles is designed to increase access to preventive oral health services, helping children avoid more significant health problems later in life. Since its inception, RIte Smiles has:

- Expanded the network of dental providers who serve children enrolled in Medicaid, increasing the number of dentists participating in Medicaid statewide from 27 to approximately 169 dentists at 269 practice locations (including dental specialists) as of 2010.
- Encouraged dentists to begin seeing children as young as 12 months old for their first visit.
- Dramatically increased Medicaid provider reimbursement rates.
- Increased the percentage of children with special healthcare needs (CSHCN) younger than age seven who received dental visits through the RIte Smiles program, demonstrating expanded access to oral health services for this population in Rhode Island.
- Increased access to care and use of preventive visits, resulting in Rhode Island's sixth place national ranking in 2009 for access to oral health services for children enrolled in Medicaid.

WHERE WE ARE GOING

RECOMMENDATION 1.1

Annually preserve and expand the dental health benefits and scope of covered services for all populations eligible for Medical Assistance Programs.

OBJECTIVE 1.1A

By 2016, use outcome and cost-efficiency data to expand the RIte Smiles program to include children age 11–21 years. *Potential Data Source: Medical Assistance Program Data and Policy Documentation*

OBJECTIVE 1.1B

By 2016, expand adult dental services covered by Medical Assistance Programs. Additional services to be determined. *Potential Data Source: Medical Assistance Program Data and Policy Documentation*

STRATEGIES

1. Promote an adult managed care dental benefit model.
2. Through 2016 and thereafter, provide data to support the retention of Medical Assistance dental benefits for pregnant women.
3. Collect relevant data, including the impact of the increased safety net participation on dental-related emergency department visits.
4. Provide ongoing education to members of the legislature and other state leaders.

RECOMMENDATION 1.2

Increase awareness of covered oral health services and how to access them among Medical Assistance Program participants.

STRATEGY

1. Conduct outreach to Medical Assistance participants.

RECOMMENDATION 1.3

Build effective referral systems to link populations with specialty oral health services (e.g. oral surgeons, periodontists, endodontists, and orthodontists).

OBJECTIVE 1.3A

Increase representation to a minimum of one dentist per dental specialty at Rhode Island Oral Health Commission meetings and safety net advisory committee meetings via targeted outreach campaign. Timeline to be determined. *Potential Data Source: Rhode Island Oral Health Commission Membership List*

STRATEGIES

1. Identify successful local specialty referral programs and highlight them as a best practice.
2. Promote program replication in additional Rhode Island dental safety net sites.

RECOMMENDATION 1.4
Improve Medical Assistance reimbursement for all dental providers.

OBJECTIVE 1.4A

By 2016, increase Medical Assistance fee-for-service reimbursement rates to within 95% of commercial rates for all dental providers, including private, safety net, and specialty providers. *Potential Data Source: Rhode Island Medical Assistance Program*

STRATEGY

1. Advocate for adequate financing of oral health services for underserved children, low-income adults, and other special populations, including elders and individuals with special healthcare needs.

RECOMMENDATION 1.5
Improve insurance reimbursement for oral health professionals.

OBJECTIVE 1.5A

By 2013, all commercial insurers in Rhode Island will provide reimbursement to oral health professionals for tobacco cessation counseling. *Potential Data Source: Rhode Island Commercial Insurer Provider Manuals*

OBJECTIVE 1.5B

By 2016, the Medical Assistance Program will provide reimbursement to oral health professionals for tobacco cessation counseling. *Potential Data Source: Medical Assistance Provider Manuals*

RECOMMENDATION 1.6
Increase utilization of the Medical Assistance program, including the use of covered support services such as transportation, translation, care coordination, outreach, and other enabling services, for program enrollees and oral health providers.

OBJECTIVE 1.6A

By 2016, increase the use of covered support services for Medical Assistance enrollees by 50%. *Potential Data Source: To Be Determined*

STRATEGIES

1. Assess current usage and barriers to utilizing existing services.
2. Provide transportation, translation, care coordination, outreach, and other enabling services to facilitate the delivery of oral health services to patients enrolled in Medicaid.
3. Increase capacity of Medical Assistance providers to see more patients.
4. Simplify the application for Medical Assistance enrollees.
5. Simplify the reimbursement process.
6. Develop policies to improve coordination between the Rhode Island Department of Human Services and federally qualified health centers.

RELATED RECOMMENDATIONS, OBJECTIVES, AND STRATEGIES

3.4: Expand the patient-centered medical home model to include oral health. (page 19)

3.5: Increase knowledge of the dental/medical home model among dental practices in Rhode Island. (page 19)

5.6B: By 2013, provide continuing education to 150 oral health providers to improve care for underserved populations. (page 26)

GOAL 2:

IMPLEMENT EVIDENCE-BASED ORAL HEALTHCARE:
EFFECTIVELY APPLY EVIDENCE-BASED SCIENCE AND BEST PRACTICES TO IMPROVE ORAL HEALTH.

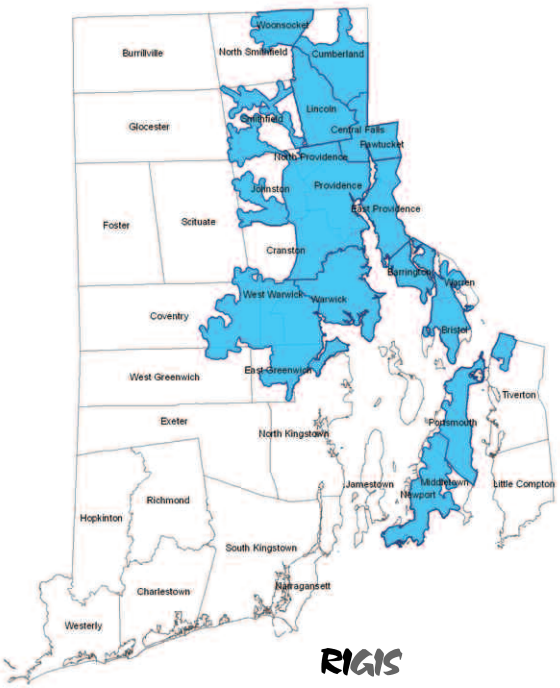
The term *evidence-based* refers to the use of science to make safe and effective public health or clinical practice recommendations and to develop programs and policies that improve oral health and prevent oral disease in the community. Systematic evaluation, which measures the safety and efficacy of interventions, is integral to the development and implementation of evidence-based practices.

The Rhode Island Oral Health Commission recognizes the importance of grounding all recommendations in evidence-based science. This section discusses the current use of several evidence-based oral health practices in Rhode Island, understanding that science must drive future action in each of the plan's six priority goal areas. Many of the practices discussed in this section are important components of an overall oral disease prevention and health promotion strategy, discussed in more detail in the next section of this plan.

FIGURE 5.

Community Water Fluoridation among Rhode Island Communities, 2010

Source: CDC Water Fluoridation Reporting System



WHAT WE HAVE DONE

Topical Fluoride Treatments

Application of topical fluoride treatments, an evidence-based practice, decreases and prevents the need for costly restorative care in young children. As a result of efforts during the past two years to increase the use of this practice:

- Primary care providers can now be reimbursed for fluoride varnish application on children enrolled in RIte Care.
- Pediatric and family practice clinicians and their staff in private practice and safety net sites are being trained in how to apply fluoride varnish, increasing the skill level and comfort with this practice.

Community Water Fluoridation (CWF)

CWF is the process of adjusting the natural fluoride concentration of a community's water supply to a level that is safe and effective for the prevention of dental caries. CWF has been recognized as one of the 10 great achievements of public health in the 20th century.[11] As of 2010, Rhode Island's CWF program covers 827,000 individuals, or 79% of the total population and 88% of the population served by public water systems (Figure 5).

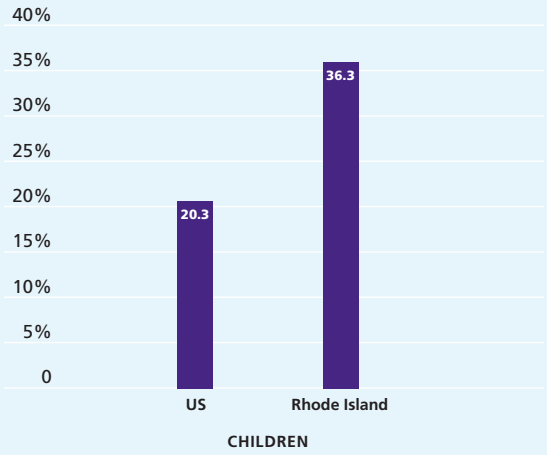
Dental Sealant Application

When combined with the appropriate use of fluoride, the routine use of dental sealants is a scientifically sound and cost-effective practice that could prevent most tooth decay in children. According to evidence-based clinical recommendations from the American Dental Association Council on Scientific Affairs, and supported by the American Academy of Pediatric Dentistry (AAPD), dental sealants should be placed on all children's and adolescents' permanent molar teeth when patients are at risk for tooth decay.[12,13] However, only 36% of Rhode Island children in third grade (children age 8–9 years) received dental sealants in 2007 (Figure 6), suggesting that more work is needed in this area.

FIGURE 6.

Rhode Island 3rd Grade Children (8–9 Years) Who Receive Dental Sealants Compared to United States Children (6–8 Years)

Source: US data from the National Health and Nutrition Examination Survey 1999–2004. Rhode Island data from the Oral Health of Rhode Island's Children. Rhode Island Department of Health. April 2008.



School-Based Dental Programs

School-based dental programs are an effective way to prevent tooth decay and reduce oral health disparities among children. These programs are especially important to the oral health of children who are less likely to receive private dental care, since preventive services are brought directly to children in the school setting. As such, the school-based dental programs in Rhode Island target high-risk children living primarily in core cities. In 2007, third grade children attending schools that had a school-based dental program received more sealants than children attending schools not serviced by a school-based program[1], suggesting the effectiveness of these programs in delivering preventive health services to the children who may need them most.

School-Based Oral Health Screenings

School-based oral health screenings are an effective way to measure children's oral health, by closely observing the mouth for treated and untreated dental decay, gum disease, and other oral health issues, as well as for the presence of dental sealants. Rhode Island Rules and Regulations for School Health Programs require that every student receive an annual dental screening by a licensed dentist or dental hygienist through the fifth grade and at least one screening between the sixth and tenth grades. To meet these requirements, every school district contracts with a licensed practicing Rhode Island dentist. Some schools contract with school-based dental programs that provide expanded oral health and preventive services.

When an annual screening reveals a potential dental problem, a school nurse teacher notifies the parent so a dental visit can be scheduled. Currently, however, the information that parents receive may vary depending upon the school's protocol and/or reporting form. To ensure that all Rhode Island children receive consistent, high quality dental screenings, standardized reporting to parents that specifically identifies the suspected oral health problem may be beneficial.

WHERE WE ARE GOING

RECOMMENDATION 2.1
Increase the use of topical fluorides as a proven therapeutic agent.

OBJECTIVE 2.1A
By 2013, increase the use of fluoride varnish applications by primary care medical providers to 20%. *Potential Data Source: Medical Assistance Program, Commercial Insurance Tracking Data*

ACTIVITIES:

1. Convene a statewide training session to educate primary care medical providers on pediatric oral health, risk assessment, anticipatory guidance, and the use of evidence-based preventive strategies, including the use of fluoride varnish.
2. Provide ongoing technical assistance to conference participants.
3. Provide trainings for medical providers on a biannual or as-needed basis.
4. Engage in ongoing collaboration with RIte Care plans, American Academy of Pediatrics, American Academy of Family Physicians, and Rhode Island Department of Human Services.
5. Assess the use of the fluoride varnish code using Medical Assistance data; analyze data prior to/following the Pediatric Oral Health Conference and periodically thereafter.

OBJECTIVE 2.1B
By 2013, increase the use of fluoride varnish applications by general dentists by 20%. *Potential Data Source: RIte Smiles Program, Commercial Insurance Tracking Data*

ACTIVITIES:

1. Analyze the results of the topical fluoride survey and disseminate to the Rhode Island Oral Health Commission.
2. Identify opportunities to provide continuing education on the benefits of fluoride varnish and the importance of establishing a Dental Home and Age 1 Dental Visit for all children.
3. Collaborate with AAPD and Rhode Island pediatric dentists.
4. Assess the use of fluoride varnish code using RIte Smiles data.
5. Develop strategies to assess and track fluoride varnish reimbursement by third party payers in Rhode Island; evaluate utilization by providers when benefits implemented.

RECOMMENDATION 2.2
Sustain and assure the quality of community water fluoridation.

STRATEGIES
1. Continue to monitor fluoride levels in public water systems monthly.
2. Continue to participate in CDC's Water Fluoridation Reporting System and My Water's Fluoride reporting system.
3. Conduct periodic inspections.
4. Conduct biannual fluoridation training for water facility operators.
5. Provide ongoing training and technical assistance to water facility operators.
6. Seek funding for the replacement of aged fluoridation equipment.
7. Support community based efforts to fluoridate public water systems that currently contain suboptimal levels of fluoride.

RECOMMENDATION 2.3
Increase the use of dental sealants.

OBJECTIVE 2.3A
By 2013, increase the use of dental sealants for children to 50%. *Potential Data Source: 2007 & 2010-2011 Basic Screening Survey (BSS); Medicaid Encounter Data*

OBJECTIVE 2.3B
By 2013, all commercial insurers in Rhode Island will provide coverage of dental sealants in their base plans. *Potential Data Source: Commercial Insurer Provider Manuals*

STRATEGIES

1. Implement strategies outlined in the 2010 Rhode Island Strategic Dental Sealant Plan.
2. Analyze the sealant rate from the 2010-2011 BSS; compare to the 2007 rate.

RECOMMENDATION 2.4
Increase participation in school-based/school-linked programs.

OBJECTIVE 2.4A

By 2013, establish school-based/school-linked programs in elementary schools with ≥40% of enrolled students eligible for free or reduced school meals. Target to be determined. *Potential Data Source: Rhode Island Department of Health (HEALTH)*

OBJECTIVE 2.4B

By Fall 2015, increase participation in school-based/school-linked programs for all elementary schools with ≥40% of enrolled students eligible for free or reduced school meals. Baseline and target to be determined. *Potential Data Source: HEALTH, School-Based/School-Linked Program Survey*

STRATEGIES

1. Identify potential resources/funding sources.
2. Develop a list of funding sources to share with school-based and community-based dental programs.
3. Develop a collaborative narrative and report that school- and community-based dental programs can use to procure funding.
4. Develop strategies to increase the participation rate/number of children served in existing programs.
5. Promote school-based/linked dental programs to school personnel and communities.

RECOMMENDATION 2.5
Standardize the mandatory annual school dental screening protocol and reporting process.

OBJECTIVE 2.5A

By 2013, develop a standardized form for recording results of school dental screenings. *Potential Data Source: HEALTH, Rhode Island Department of Education (RIDE)*

OBJECTIVE 2.5B

By 2013, 100% of school dentists and school personnel will have access to the standardized form for recording results of school dental screenings. *Potential Data Source: HEALTH and RIDE Websites*

OBJECTIVE 2.5C

By 2012, the Rhode Island Department of Health will develop a database for screening results from school dental screenings. *Potential Data Source: HEALTH*

OBJECTIVE 2.5D

By 2013, 100% of schools will report annual dental screening data to the Rhode Island Department of Health. *Potential Data Source: HEALTH*

STRATEGIES

1. Solicit suggestions/input from school dentists regarding potential changes to the School Health Rules & Regulations, Section 14.0 *Dental Health Screening*.
2. Incorporate suggested revisions; propose to RIDE/HEALTH.
3. Provide professional development opportunities for school dentists; convene group on an annual or as-needed basis.

RELATED RECOMMENDATIONS, OBJECTIVES, AND STRATEGIES

1.1, Strategy 2: Through 2016 and thereafter, provide data to support the retention of Medical Assistance dental benefits for pregnant women. (page 10)

3.3: Increase awareness and knowledge of the importance of prenatal, maternal, and infant oral health and the benefits of establishing positive oral health habits in infancy among oral health and medical professionals and the public. (page 19)

GOAL 3:

**PREVENT ORAL DISEASE, PROMOTE ORAL HEALTH:
DEVELOP A COMPREHENSIVE ORAL DISEASE PREVENTION AND HEALTH PROMOTION SYSTEM.**

Common oral diseases are often preventable, but current oral health promotion and disease prevention measures do not reach all community members. Despite making statewide progress in improving oral health status for many Rhode Islanders, profound oral disease disparities still exist related to socioeconomic status, race/ethnicity, age, gender, and other risk factors.

Schools, community programs, the media, and healthcare settings offer many opportunities to expand oral disease prevention and health promotion efforts. For example, oral healthcare providers can incorporate tobacco cessation programs into their practices, while medical providers can provide oral health risk assessments and fluoride varnish applications for high risk children during well-child visits.

This section highlights focus areas for local health promotion and disease prevention efforts over the next five years. The major challenge for Rhode Island will be to translate knowledge and experiences about disease prevention into coordinated, evidence-based programs that impact all residents. Since oral health contributes to overall health, efforts should be integrated with cross-cutting, statewide health initiatives whenever possible.

WHAT WE HAVE DONE

Oral Health Education

Oral health education informs, motivates, and helps people to adopt and maintain beneficial oral health practices and lifestyles. In 1996, the Rhode Island Department of Education (RIDE) identified a vision for health education in the state as "a comprehensive, sequential, kindergarten through grade 12 program, resulting in students who choose to live healthy lifestyles" and established specific healthy lifestyle goals.[14] In 2003, RIDE recognized the importance of integrating oral health into this comprehensive health education curriculum by identifying oral health, hygiene, and disease prevention as instructional standards that students must meet in grade levels K-4 and 5-8.[15]

Preventive Dental Visits

Regular preventive dental care, such as teeth cleanings, can reduce oral disease and facilitate its early diagnosis and treatment. However, many Rhode Island children and adults do not visit the dentist regularly. Of all Rhode Island children, those age 1–5 years had the lowest percentage of dental check-up and cleaning visits in 2008. Minority children and those with lower family income, public dental insurance coverage, or no dental insurance also are less likely to receive preventive childhood dental visits (Figure 7). For both children and adults, receipt of dental services often depends on dental insurance status and the type of coverage owned. Please see Goal 1 for more information about identifying and removing the barriers that keep Rhode Islanders from accessing oral healthcare services.

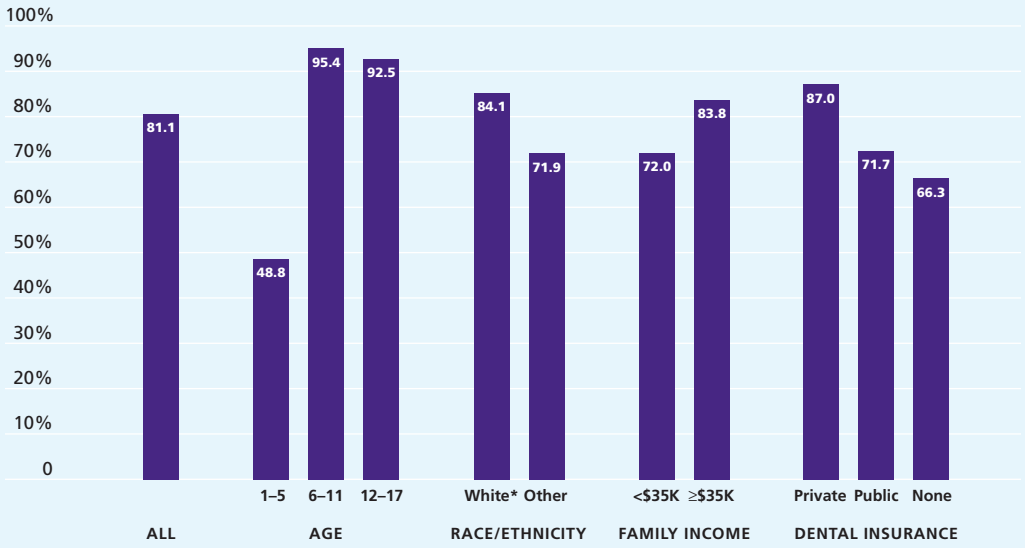
Oral Cancer Screening

Oral cancer can be detected by a thorough examination of the head, neck, areas of the mouth, and lymph nodes. Early detection and treatment of precancerous lesions and diagnosis of oral cancer at localized stages are considered to be the main approaches for secondary prevention of these cancers.[16,17,18] Rhode Island needs to make significant progress from the current oral and pharyngeal cancer early detection rate of 33% to reach the Healthy People 2020 goal of 35.8%.[19] Additionally, the importance of regular oral cancer screenings increases with age. In 2008, 41% of Rhode Island adults age 40+ years reported receiving an oral cancer examination within the last year. This screening rate exceeded the national average of 19%. However, significant disparities were noted by race/ethnicity, education level, household income, and dental insurance status (Figure 8).

FIGURE 7.

Rhode Island Children (1–17 Years) with Dental Checkup and Cleaning in the Past 12 Months, 2008

Source: Rhode Island Behavioral Risk Factor Surveillance System, 2008



*Non-Hispanic White

FIGURE 8.

Rhode Island Adults Age 40+ Years Who Received an Oral and Pharyngeal Cancer Exam within the Past 12 Months, 2008

Source: Rhode Island Behavioral Risk Factor Surveillance System, 2008

*Non-Hispanic White

Prenatal/Maternal/Children's Oral Health

As discussed in the section "The Burden and Disparity of Oral Diseases in Rhode Island," several studies have shown a relationship between oral health and negative birth outcomes. In addition to ensuring pregnant women can access oral healthcare services (discussed in Goal 1), improving a mother's knowledge of appropriate oral hygiene and feeding practices may benefit both her own health and her baby's development, birth outcomes, and oral health after birth.

The Dental Home Model

Based on the medical home model, the dental home model embraces the concept that an established partnership between a dentist and a patient fosters accessible, coordinated, comprehensive, and family-centered primary care. A dental home allows for early intervention with strategies tailored to an individual patient's risk for developing oral disease. Promoting the dental home model in Rhode Island and integrating providers within the medical home model may further not only oral health, but also overall health promotion strategies.

WHERE WE ARE GOING

RECOMMENDATION 3.1

Increase knowledge among non-dental health providers, associated staff, and insurers of oral disease prevention measures for targeted populations, including but not limited to infants and toddlers, school-aged children, adolescents, perinatal women, adults, elders, and individuals with special healthcare needs.

STRATEGIES

1. Promote the ongoing incorporation/expansion of oral disease prevention by medical providers, particularly during well-child and perinatal visits.
2. Support oral health promotion efforts to members of private and publicly funded insurance plans.
3. Integrate oral health education into hospital childbirth and parenting educational programs.
4. Provide oral health education to nursing home facility staff.
5. Provide oral health promotion/disease prevention education to families and individuals with special healthcare needs, including currently available Rhode Island supportive resources.

RECOMMENDATION 3.2

Increase integration of oral health and overall health in multidisciplinary statewide health initiatives.

OBJECTIVE 3.2A

By 2016, increase the Rhode Island Oral Health Commission representation from non-traditional partners, including but not limited to the business community, medical professionals, medical societies, and educational institutions. Target to be determined. *Potential Data Source: Rhode Island Oral Health Commission Membership List*

OBJECTIVE 3.2B

By 2016, increase the use of referrals to tobacco cessation initiatives by dental providers. Baseline and target to be determined. *Potential Data Source: To Be Determined*

STRATEGIES

1. Collaborate with statewide initiatives and programs targeting chronic diseases/conditions, including diabetes, heart disease, cancer, and HIV/AIDS.
2. Collaborate with statewide health promotion and wellness initiatives, including maternal and child health, nutrition, and healthy weight programs.
3. Ensure that the Rhode Island Department of Education keeps oral health as a health topic in its core curricula and competencies.

RECOMMENDATION 3.3

Increase awareness and knowledge of the importance of prenatal, maternal, and infant oral health and the benefits of establishing positive oral health habits in infancy among oral health and medical professionals and the public.

OBJECTIVE 3.3A

By 2013, increase the number of pregnant women who visit an oral health professional during pregnancy. Baseline and target to be determined. *Potential Data Source: Medical Assistance Program, Pregnancy Risk Assessment Monitoring System (PRAMS)*

OBJECTIVE 3.3B

By 2013, increase the number of children receiving dental visit by age one year. Baseline and target to be determined. *Potential Data Source: RIte Smiles Program*

STRATEGIES

1. Conduct outreach to obstetricians, gynecologists, certified nurse midwives, family practice physicians, and statewide training programs to integrate oral health education into professional development and curricula.
2. Conduct outreach to birthing hospitals to integrate oral health education for staff and new parents.
3. Provide continuing education opportunities for oral health professionals, including but not limited to mini-residencies, small group lectures/focus groups, and online trainings/resources.
4. Develop referral resources for establishment of prenatal oral healthcare and Dental Home/Age 1 dental visit.
5. Monitor statewide surveillance systems (PRAMS).

RECOMMENDATION 3.4

Expand the patient-centered medical home model to include oral health.

STRATEGIES

1. Review health home models in other states.
2. Develop recommendations for interdisciplinary health home models of care in Rhode Island.
3. Convene a workgroup to make recommendations regarding the integration of dental homes into the medical home model.

RECOMMENDATION 3.5

Increase knowledge of the dental/medical home model among dental practices in Rhode Island.

STRATEGY

1. Collect and share information with oral health professionals regarding the dental home model.

RELATED RECOMMENDATIONS, OBJECTIVES, AND STRATEGIES

1.3: Build effective referral systems to link populations with specialty oral health services (e.g. oral surgeons, periodontists, endodontists, and orthodontists). (page 10)

GOAL 4:

MAINTAIN THE DENTAL SAFETY NET:
ASSURE A STRONG DENTAL SAFETY NET INFRASTRUCTURE.

A strong dental safety net ensures access to oral healthcare services for underserved populations. Dental safety net providers offer oral healthcare services regardless of an individual's insurance status or ability to pay. The comprehensive dental services they provide include preventive, diagnostic, restorative, rehabilitative, surgical, and emergency dental services. Rhode Island's current dental safety net includes St. Joseph Center for Health and Human Services Pediatric Dental Center, Samuels Sinclair Dental Center at Rhode Island Hospital, nine community health centers, and the Community College of Rhode Island. These providers are critical to the state's current and future healthcare delivery system.

In addition to working in dental safety net sites, a variety of Rhode Island oral health professional associations and individual providers volunteer their time. This provides a limited way for underserved Rhode Island residents to receive needed services that may not otherwise be available. Examples of ongoing volunteer events in Rhode Island include:

- Give Kids a Smile®: In cooperation with the Rhode Island Dental Association and the American Dental Association, many Rhode Island dentists participate in this one-day annual event, which encourages dental professionals nationwide to provide free oral healthcare services to children from low-income families.
- Donated Dental Services (DDS)/Donated Orthodontic Services (DOS): Since 1989, 180 Rhode Island dentists have volunteered their time and services through the DDS program and have provided an array of no-cost dental services exceeding $184,000 per year to over 140 qualified patients. The DOS program was introduced in 2009.
- National Children's Dental Health Month: Through the Rhode Island Dental Hygienists' Association, dental hygienists annually provide oral health promotion and interactive education to children in schools and at the Providence Children's Museum.

Although the dental safety net has increased access to oral healthcare over the past decade, staff vacancies still negatively impact the provision of comprehensive, timely dental services. Reported personnel recruitment challenges include low salary levels compared to the private sector and nearby states, lack of in-state training and education programs for dentists, and too few applicants interested in working with underserved populations. (Please see Goal 5 for more information on oral health workforce challenges.) Over the next five years, Rhode Island must maintain its current dental safety net and strengthen access to existing oral healthcare services. At the same time, the state must continue working to expand access to oral healthcare for everyone, including underserved populations.

WHAT WE HAVE DONE

Rhode Island state government, private funders, community health centers, hospital dental clinics, dental hygiene schools, and volunteer organizations made a concerted effort over the past decade to increase the capacity of the dental safety net. Together, dental safety net providers have improved access to care for children, adults, and elders by:

- Increasing the number of dental treatment rooms and staff at their practice locations.
- Establishing or greatly expanding school-linked dental programs in the communities they serve.
- Establishing mobile dental services throughout Rhode Island for children and elders.
- Increasing oral health professional training opportunities and hosting a variety of volunteer programs.
- Upgrading facilities to provide better and more comprehensive services.

WHERE WE ARE GOING

RECOMMENDATION 4.1

Maintain current safety net capacity (facilities, funding, operatories, and staff) to provide oral health services to underserved populations in clinical, school-based, and community settings.

OBJECTIVE 4.1A

By the end of 2011 and 2014, conduct a survey among 100% of dental safety net providers to assess the current capacity of the dental safety net (facilities, funding, operatories, and staff). *Potential Data Source: Rhode Island Health Center Association (RIHCA), Rhode Island KIDS COUNT, Rhode Island Department of Health (HEALTH)*

OBJECTIVE 4.1B

By 2012 and 2015, develop and distribute *The Dental Safety Net in Rhode Island* report based on data from the dental safety net surveys to all identified stakeholders and policymakers. *Potential Data Source: RIHCA, Rhode Island KIDS COUNT, HEALTH*

RECOMMENDATION 4.2

Expand the dental safety net in Rhode Island.

OBJECTIVE 4.2A

By 2016, increase funding for the dental safety net infrastructure by 10%. *Potential Data Source: Dental Safety Net Survey and Report*

ACTIVITY:

1. Monitor additional funding opportunities to expand capacity and services through the health safety net.

OBJECTIVE 4.2B

By 2016, increase the number of dental safety net site providers by 10%. *Potential Data Source: Dental Safety Net Survey and Report*

STRATEGIES

1. Monitor opportunities to expand capacity under healthcare reform.
2. Evaluate the safety net for ways to increase efficiency using existing resources.
3. Research innovative methods to measure safety net capacity (e.g., Rhode Island Department of Human Services, providers, Dental Health Professional Shortage Area survey).
4. Educate community providers regarding dental care and the safety net.
5. Report safety net data to interested parties, such as Rhode Island Oral Health Commission members, policy makers, and policy advocates.

RECOMMENDATION 4.3

Support safety net providers with information and evidence-based practices on treating different populations.

STRATEGY

1. By 2013, provide annual educational opportunities for safety net and other oral health workforce staff on the provision of high quality, culturally and linguistically appropriate oral health services for populations served by the safety net to assure there is an adequate and skilled workforce.

RELATED RECOMMENDATIONS, OBJECTIVES, AND STRATEGIES

1.1: Annually preserve and expand the dental health benefits and scope of covered services for all populations eligible for Medical Assistance Programs. (page 10)

1.3: Build effective referral systems to link populations with specialty oral health services (e.g. oral surgeons, periodontists, endodontists, and orthodontists). (page 10)

1.4: Improve Medical Assistance reimbursement for all dental providers. (page 11)

3.4: Expand the patient-centered medical home model to include oral health. (page 19)

3.5: Increase knowledge of the dental/medical home model among dental practices in Rhode Island. (page 19)

GOAL 5:

SUSTAIN THE ORAL HEALTH WORKFORCE:
ASSURE AN ADEQUATE AND EFFECTIVE ORAL HEALTH WORKFORCE IN RHODE ISLAND.

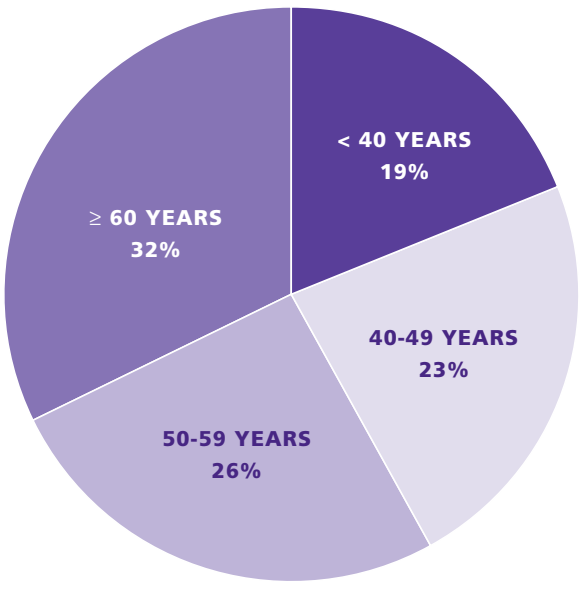
A robust, adequately trained, skilled, and diverse workforce is essential to ensuring access to high quality oral health services for all. The nation's oral health workforce, however, currently fails to meet the needs of many people. Workforce challenges cited by the Institute of Medicine include limited coordination and integration of oral health, medical, and public health systems of care; payment and education systems that focus on treatment rather than disease prevention; an insufficient evidence base for many dental procedures and workforce models; and regulatory barriers that prevent the exploration of alternative models of care.[20]

Approximately 97% of Rhode Island dentists work in private practices, while 3% work in a public health setting, such as in a dental safety net site.[21] To improve oral health outcomes and eliminate disparities, Rhode Island's oral health workforce must provide both preventive and restorative care for individuals via both types of sites. (Please see Goal 4 for more information about the state's dental safety net.) Workforce members should coordinate public health activities for underserved populations. In addition, the state should continuously monitor dental workforce trends to assure a sufficient provider supply and develop responsive, flexible workforce strategies.

FIGURE 9.

Actively Licensed Dentists in Rhode Island by Age (Total dentists* = 619)

Source: Rhode Island License Database (License2000®) as of September 2010. Rhode Island Office of Health Professionals Regulation



*Dentists with Rhode Island practice addresses

The Dental Team

The dental team is comprised of dentists, dental hygienists, dental assistants, and laboratory technicians. This team can work in private practice, within a dental safety net site, such as a community health center, hospital or clinic, and/or volunteer their time and services. (Please see Goal 4 for more information about Rhode Island's dental safety net sites and volunteer activities.)

As of September 2010, 619 actively licensed dentists were practicing in Rhode Island, or 59 dentists per 100,000 Rhode Island residents. Rhode Island's dentist to population ratio is favorable when compared to the national average (47:100,000). However, dentists are not evenly distributed across the state, and they do not uniformly accept individuals with all types of insurance coverage. Increased shortages are expected in the next decade: more than half of actively practicing Rhode Island dentists are approaching retirement age (50+ years) (Figure 9), and the state has a less than optimal supply of expert faculty to train students seeking entry into this profession. Most importantly, these shortages will likely impact the state's most underserved populations—families with low income, individuals with special healthcare needs, elders in nursing facilities, and people of minority race/ethnicity.

As of September 2010, 713 actively licensed registered dental hygienists were practicing in Rhode Island. Dental hygienists in Rhode Island practice under "general supervision," which means that a dentist must authorize the procedures to be performed but need not be present while the dental hygienist provides the services. Dental hygienists in other states have less restrictive supervision and can perform expanded functions, such as placement

of restorative materials, periodontal dressing, suture removal, and metal restoration polishing. Revisiting regulatory requirements for dental hygienists to expand their roles may allow Rhode Island to improve access to oral healthcare services, particularly for vulnerable populations who are not able to access traditional dental practices, either due to geographical, cultural, or financial barriers.

Rhode Island does not license dental assistants, making it difficult to quantify the number currently practicing in Rhode Island. Without licensure, continuing education is not required; therefore, mastery of topics, such as infection control and radiation health and safety, whose content changes over time, is not a requirement for employment. Education in these topics may increase the safety of both dental assistants and their patients. Rhode Island also does not license dental laboratory technicians, making it difficult to quantify the number currently practicing in Rhode Island.

WHAT WE HAVE DONE

Although Rhode Island does not have a dental school, several educational opportunities established since 2000 have increased the number of appropriately trained and culturally competent oral health providers. These opportunities include:

- Recently established dental residency programs that educate dentists in advanced clinical skills and help recruit dentists to practice in Rhode Island beyond their residency.
- Annual mini-residency programs that provide continuing education to oral health professionals statewide in the areas of pediatric, special care, geriatric, and adolescent dentistry, as well as culturally and linguistically appropriate services (CLAS) standards.
- Upgraded facilities at the Dental Hygiene Clinic at the Community College of Rhode Island (CCRI), which now serves as the main dental hygiene education site in the state.

WHERE WE ARE GOING

RECOMMENDATION 5.1
Maintain and reinforce the oral health workforce.

STRATEGY

1. Convene the Rhode Island Oral Health Commission Workgroup on Oral Health Workforce quarterly to monitor the status of the oral health workforce and identify strategies to plan for the replacement of dental practitioners at or near retirement.

RECOMMENDATION 5.2
Assess gaps in the oral health workforce in Rhode Island.

OBJECTIVE 5.2A

By 2011, develop a report that identifies areas of underservice, current dental health professional shortages, and other oral health workforce needs in Rhode Island. *Potential Data Source: Dental Health Professional Shortage Area (DHPSA) Survey Data*

ACTIVITIES:

1. Develop a survey to assess dentist practice patterns, locations, and hours devoted to direct patient care.
2. Disseminate the survey electronically and via hard copy to all Rhode Island licensed dentists; promote survey participation via the Rhode Island Dental Association website.
3. Complete analysis of survey results; produce workforce report by 2011.

OBJECTIVE 5.2B

By 2015, establish a Rhode Island Dental Assistant Registry to facilitate ongoing assessment of the dental assistant workforce, communicate continuing education and training opportunities, monitor the need for continuing education on key and emerging topics, including the areas of infection control and radiation safety, and promote opportunities for preparatory courses leading to certified dental assistant (CDA) status. *Potential Data Source: To Be Determined*

ACTIVITIES:

1. Develop a survey of Rhode Island dentists to assess the dental assistant workforce.
2. Disseminate the survey electronically and via hard copy to all licensed Rhode Island dentists; promote survey participation via the Rhode Island Dental Association website.
3. Complete analysis of survey results by 2012.
4. Research Dental Assistant Registry models from other states.
5. Develop and conduct training courses to prepare on-the-job trained dental assistants for certification examinations offered by the Dental Assisting National Board (DANB).
6. Use the registry to monitor changes in the dental assisting workforce.

RECOMMENDATION 5.3
Recruit new practitioners into the oral health professional workforce in Rhode Island.

OBJECTIVE 5.3A

By 2012, recruit at least 10 new dentists to Rhode Island private practices and dental safety net sites. *Potential Data Source: Rhode Island Department of Health Annual Licensure Data*

ACTIVITIES:

1. Develop and expand programs to incentivize primary care dentists, dental specialists, and other oral health professionals to practice in Rhode Island (particularly in areas with underserved populations) including, but not limited to, educational loan repayment programs, tax incentives, licensure fee waiver, and/or support of liability coverage for volunteer providers in safety net sites.
2. Develop customized, coordinated recruitment materials for students graduating from New England dental schools.
3. Promote Rhode Island practice opportunities via outreach and mentorship including, but not limited to, personalized letters or other communication from Rhode Island Oral Health Commission leadership.
4. Monitor licensure data for changes in the dental workforce.

OBJECTIVE 5.3B

By 2013, identify at least two strategies to support qualified students interested in dental hygiene or dental assisting careers. Format to be determined. *Potential Data Source: Rhode Island Oral Health Commission*

ACTIVITY:

1. Seek funding to support scholarships, tuition, and child care support for qualified candidates seeking dental hygiene and dental assisting education and careers.

RECOMMENDATION 5.4

Retain dental health professionals in the oral health workforce in Rhode Island.

STRATEGIES

1. Develop and expand programs to incentivize currently licensed primary care dentists, dental specialists, and other oral health professionals to continue practicing in Rhode Island (particularly in areas with underserved populations) including, but not limited to, educational loan repayment programs, tax incentives, licensure fee waiver, and/or support of liability coverage for volunteer providers in safety net sites.
2. Develop survey methods and outreach to oral health professionals including, but not limited to, conducting exit surveys of dentists who opt not to renew Rhode Island Dental Association membership or Rhode Island licensure and interviewing newly licensed practitioners to determine attitudes related to establishing and sustaining a viable dental practice in Rhode Island.
3. Explore how changes in scope of practice for dental hygienists and dental assistants can contribute to the viability and sustainability of Rhode Island dental practices.
4. Monitor licensure data for changes in the dental workforce.

RECOMMENDATION 5.5

Promote dental careers to math- and science-minded youth, particularly among youth of minority race/ethnicity or from disadvantaged families.

OBJECTIVE 5.5A

By 2012, develop partnerships with at least two middle schools or high schools. *Potential Data Source: To Be Determined*

ACTIVITIES:

1. Develop guidelines and materials for use by oral health professionals interested in mentoring youth to pursue careers in dentistry, dental hygiene, dental assisting, and/or dental laboratory technology.
2. Establish formal relationships with school districts to promote oral health careers in conjunction with community service, portfolio, or other graduation requirements for students.
3. Conduct outreach to youth organizations with community service and service learning requirements including, but not limited to, Boys Scouts, Girl Scouts, and youth sports associations.

OBJECTIVE 5.5B

By 2013, develop partnerships with pre-medical and pre-dental advisors in at least two New England post-secondary schools or colleges. *Potential Data Source: To Be Determined*

ACTIVITIES:

1. Develop guidelines and materials for use by oral health professionals interested in mentoring post-secondary students to pursue careers in dentistry.
2. Coordinate promotion of dental careers and scholarship opportunities with the Health Resources and Services Administration (HRSA) National Health Service Corps (NHSC) Ambassador and Scholar Programs; utilize NHSC dental scholars currently practicing in Rhode Island as oral health champions for the underserved.
3. Develop affiliation agreements with out-of-state dental schools to expand opportunities for externships or clinical rotations at Rhode Island sites.

OBJECTIVE 5.5C

By 2012, develop and maintain affiliation agreements or partnerships with at least one New England dental school to create an enrollment slot for at least one Rhode Islander in each affiliated dental school in exchange for Rhode Island service obligation upon graduation. *Potential Data Source: To Be Determined*

RECOMMENDATION 5.6
Expand dental education opportunities in Rhode Island.

OBJECTIVE 5.6A

By 2014, develop a plan to expand advanced dental education programs in Rhode Island including, but not limited to, dental residency and/or fellowship programs for primary care dentists and dental specialists, particularly oral maxillofacial surgeons. *Potential Data Source: Rhode Island Oral Health Commission*

ACTIVITIES:

1. Research advanced dental education models and identify opportunities to expand dental residency training programs for primary care dentists and dental specialists, particularly oral maxillofacial surgeons.
2. Seek funding to support advanced training.
3. Recruit qualified faculty and candidates for advanced dental education programs.

OBJECTIVE 5.6B

By 2013, provide continuing education to 150 oral health providers to improve care for underserved populations. *Potential Data Source: To Be Determined*

ACTIVITIES:

1. Research current American Dental Association dental clinic requirements and regulations regarding individuals with special healthcare needs.
2. Survey Rhode Island oral health professionals to determine practice needs that would encourage provision of care for individuals with special healthcare needs.
3. Convene continuing education event to educate oral health professionals.

RECOMMENDATION 5.7
Enhance the integration of medicine and dentistry to improve the overall health status of Rhode Island residents.

STRATEGIES

1. Conduct outreach to health systems/networks and health professions training programs in Rhode Island.
2. Identify training needs; develop interdisciplinary educational programs in collaboration with partners.
3. Conduct continuing education programs, as needed.

RELATED RECOMMENDATIONS, OBJECTIVES, AND STRATEGIES

4.3: Support safety net providers with information and evidence-based practices on treating different populations. (page 21)

6.2: Maintain, assess, and advocate for, as needed, adequate oral health public health staffing and infrastructure within state government and at the community level. (page 29)

6.3: Educate stakeholders and policymakers on the status and progress of health reform, its potential impact on oral health, and opportunities to reinforce the oral health workforce in Rhode Island. (page 29)

6.4: Explore licensure standards and promising practice models from other states for their potential to reinforce the oral health workforce in Rhode Island. (page 29)

GOAL 6:

INFORM ORAL HEALTH POLICY DECISIONS:
ASSURE ADEQUATE AND APPROPRIATE INFORMATION IS AVAILABLE FOR EFFECTIVE POLICY DECISIONS.

In addition to establishing oral health policies and regulating oral health professionals, legislators, state departments, federal agencies, insurers, and many other organizations regularly make policy decisions that indirectly impact residents' oral health. Rhode Island must continue to identify and push for policy changes that will lead to improved oral health outcomes for all populations. This includes ensuring that policy makers base their decisions on fact and current reality. To establish oral health as a public policy priority, Rhode Island needs to make accurate, regular, timely, comprehensive, and user-friendly data available on the following topics: oral health status, access to oral healthcare, the efficacy of clinical treatments and community-based interventions, the oral health workforce, and best practices.

WHAT WE HAVE DONE

Rhode Island has made significant strides in recent years to develop and implement policies that help promote oral health. Based on evidence-based practices in other states and accurate data, these policies include:

- Smoking Ban in Rhode Island Workplaces: Smoking can cause oral health problems such as gum disease and tooth decay. The Public Health and Workplace Safety Act of Rhode Island, signed into law in June 2004 and extended in October 2006, requires smoke-free workplaces, including restaurants and bars.
- Licensure by Endorsement: In 2006, state regulations for dental professionals were revised to allow for licensure by endorsement for dentists and dental hygienists, provided that they hold a current license to practice in another state that requires the successful completion of a clinical board examination.
- Local Anesthesia Administration by Registered Dental Hygienists: In 2007, state regulations for dental professionals were revised to allow registered dental hygienists to administer local anesthesia once they have successfully completed an approved course in local anesthesia and passed a local anesthesia examination administered by the North East Regional Board (NERB).
- Registered Dental Hygienists in Nursing Homes: Approved in 2007, a statutory change in the Dental Practice Act allows dental hygienists to provide preventive services to nursing facility residents without the on-site direct supervision of a licensed dentist.
- Healthy Vending in Rhode Island Schools: Eating a healthy diet and limiting sweet drinks and snacks helps children keep their teeth clean and healthy. Starting in 2009, all Rhode Island schools that sell or distribute beverages and snacks on their premises, including those sold through vending machines, are required to offer only healthier beverages and snacks, as defined in state regulations.

WHERE WE ARE GOING

RECOMMENDATION 6.1
Determine a set of oral health indicators for Rhode Island.

STRATEGIES

1. Identify sources of oral health related data.
2. Promote the use of evaluation for oral health initiatives throughout Rhode Island in order to identify and replicate best practices and to create data that will inform policy decisions.
3. Provide data and other information to key stakeholders in a user-friendly format on a regular and timely basis to facilitate decision-making.
4. Identify funding sources to support ongoing evaluation and data collection activities.

RECOMMENDATION 6.2

Maintain, assess, and advocate for, as needed, adequate oral health public health staffing and infrastructure within state government and at the community level.

OBJECTIVE 6.2A

By 2014, attain a state mandate to maintain and sustain the State Oral Health Program at the Rhode Island Department of Health. *Potential Data Source: Rhode Island Office of the Secretary of State*

STRATEGIES

1. Through 2016, maintain and sustain the Rhode Island Oral Health Commission and actively solicit representatives from a wide variety of public, private and not-for-profit organizations and agencies, including insurers, private practitioners, community organizations, state agencies, professional organizations, safety net providers, policy advocates, educators, consumers, and others.
2. Through 2016 and thereafter, convene quarterly Rhode Island Oral Health Commission meetings as an opportunity for a diverse group of oral health stakeholders, including individuals and public and private organizations, to collaborate toward increasing the oral health of Rhode Island residents across the lifespan.

RECOMMENDATION 6.3

Educate stakeholders and policymakers on the progress of health reform, its potential impact on oral health, and opportunities to reinforce the oral health workforce in Rhode Island.

STRATEGIES

1. Track legislative action through key contacts and professional associations.
2. Disseminate information to all Rhode Island Oral Health Commission members on a quarterly basis.
3. Identify opportunities to enhance the oral health workforce in Rhode Island.

RECOMMENDATION 6.4

Explore licensure standards and promising practice models from other states for their potential to reinforce the oral health workforce in Rhode Island.

OBJECTIVE 6.4A

By 2011, identify at least two options to expand the scope of practice for Rhode Island dental hygienists and/or dental assistants. Format to be determined. *Potential Data Source: To Be Determined*

ACTIVITIES:

1. Review existing rules and regulations for the practice of dentistry in Rhode Island.
2. Research and compare scope of practice models from other states.
3. Propose expanded duties to enhance access to and use of efficient and proven practice models.
4. Present proposed changes at public hearing; implement appropriate regulatory changes.
5. Monitor impact of regulatory changes on access to care, particularly for underserved populations.

OBJECTIVE 6.4B

By 2013, identify at least one new provider model to enhance the delivery of oral health services in Rhode Island. Format to be determined. *Potential Data Source: To Be Determined*

ACTIVITIES:

1. Review oral health provider models in other states.
2. Develop recommendations for new Rhode Island provider type or classification as needed to assure access to high quality oral health services.

OBJECTIVE 6.4C

By 2015, identify appropriate educational and testing standards to facilitate Rhode Island practice opportunities for internationally-trained dentists. Format to be determined. *Potential Data Source: To Be Determined*

ACTIVITIES:

1. Review models in other states.
2. Recommend regulatory changes and action steps, as needed.

Acknowledgements

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Glossary

ASTDD: Association of State and Territorial Dental Directors (www.astdd.org)

BASIC SCREENING SURVEY (BSS): A dental screening to assess oral health status and identify gross dental and oral lesions. It is not a thorough examination and does not involve making a clinical diagnosis.

BRFSS: Behavioral Risk Factor Surveillance System

CCRI: Community College of Rhode Island

CDC: Centers for Disease Control and Prevention (www.cdc.gov)

CHC: Community Health Center

COMMUNITY WATER FLUORIDATION (CWF): Adjustment of the fluoride concentration in the community water supply to a level beneficial to reduce tooth decay and promote good oral health.

CORE CITY: A city where the child poverty level is greater than 15%, according to the 2000 Census. (Currently: Central Falls, Newport, Pawtucket, Providence, West Warwick, and Woonsocket)

CSHCN: Children with Special Healthcare Needs

DENTAL ASSISTANTS (DAs): Members of the dental team who assist in the delivery of oral health services by performing a wide range of duties in the dental office.

DENTAL CARIES: A disease of the teeth that causes tooth decay and cavities.

DENTAL EXAMINATION: A complete checkup by a dentist that includes an inspection of the head, neck, teeth, gums, and soft tissues of the mouth.

DENTAL HEALTH PROFESSIONAL SHORTAGE AREAS (DHPSA): Areas designated as having shortages of primary dental health providers. (http://bhpr.hrsa.gov/shortage/)

DENTAL HOME: Oral healthcare that is delivered in a comprehensive, continuously accessible, coordinated, and family-centered way by a licensed dentist.

DENTAL HYGIENISTS: Members of the dental team who focus on preventive care, such as performing cleanings and providing oral hygiene and nutrition counseling.

DENTAL LABORATORY TECHNICIANS (DLTs): Professionals who create replacements for natural teeth, such as crowns, bridges, and dentures.

DENTAL SCREENING: An inspection of the mouth to assess for any oral and dental problems. It is an appraisal activity and is not a diagnostic examination.

DENTAL SEALANTS: Thin plastic coatings that are applied to the grooves on the chewing surfaces of the back teeth to protect these teeth from tooth decay by keeping germs and food particles out of the grooves.

DHS: Rhode Island Department of Human Services (www.dhs.ri.gov)

EDENTULOUS: To be without teeth.

ENDODONTICS: Dental specialty concerned with the tooth pulp and the tissues surrounding the root of a tooth.

EVIDENCE-BASED PRACTICE: A term that refers to information obtained from scientific evidence.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs): A federal designation assigned to private non-profit or public healthcare organizations serving primarily uninsured or medically underserved populations. Also known as Community Health Centers (CHCs).

FLUORIDE VARNISH: A highly concentrated form of fluoride that is applied to the tooth surface by a healthcare professional.

FREE OR REDUCED SCHOOL MEAL (FRSM) PROGRAM: Children from households that meet federal income guidelines are eligible for free or reduced-price school meal services.

HEALTH: Rhode Island Department of Health (www.health.ri.gov)

HEALTHY PEOPLE: A set of national health objectives that was built on scientific knowledge to measure programs over time. (www.healthypeople.gov)

HRSA: Health Resources and Services Administration (www.hrsa.gov)

MEDICAID: A public insurance program available to low-income individuals and families who meet federal and state eligibility guidelines.

MEDICAL ASSISTANCE: Medicare and Medicaid programs.

MEDICAL HOME: An approach to providing comprehensive primary care that facilitates partnership between patients, physicians, and families.

MEDICARE: A public health insurance program for people age 65+ years, people younger than age 65 with certain disabilities, and all people with End-Stage Renal Disease.

PERIODONTAL DISEASE: Gum disease.

PERIODONTICS: Dental specialty concerned with the prevention, diagnosis, and treatment of diseases of the gums.

RIDE: Rhode Island Department of Education (www.ride.ri.gov)

RITE CARE: Rhode Island's Medical Assistance program.

RITE SMILES: Rhode Island's dental program for young children who are eligible for Medical Assistance coverage and who were born on or after May 1, 2000.

SAFETY NET: Healthcare providers who accept patients regardless of their ability to pay, such as uninsured and underinsured individuals and Medicaid beneficiaries. RI providers include FQHCs, hospital-based clinics, the CCRI dental hygiene clinic, private providers committed to underserved patients, and volunteer programs (Give Kids A Smile, Donated Dental Services, and free clinics).

SCHOOL-BASED/SCHOOL-LINKED DENTAL PROGRAMS: School-based programs are conducted within the school utilizing portable dental equipment or existing facilities. School-linked programs operate at a site outside the school setting. These programs are important to the oral health of underserved populations.

SNT: School Nurse Teacher

UNDERSERVED POPULATIONS: Population groups whose demographic, geographic, or economic characteristics impede or prevent their access to healthcare services.

YRBS: Youth Risk Behavior Survey

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Rhode Island Oral Health Plan: Logic Model

The **Rhode Island Oral Health Plan, 2011–2016** Logic Model showcases how the six priority goal areas and existing infrastructure will help Rhode Island reach its desired outcome for oral health: Optimal Oral Health for All Rhode Islanders.

INPUTS

Existing Infrastructure

Rhode Island Oral Health Commission with comprehensive and diverse stakeholder membership, including state agency staff

Support from national organizations: Centers for Disease Control and Prevention, Health Resources and Services Administration, Association of State and Territorial Dental Directors for technical assistance & funding

GOALS

1. Improve Access to Oral Healthcare Services see page 8
2. Implement Evidence-Based Oral Healthcare see page 12
3. Prevent Oral Disease, Promote Oral Health see page 16
4. Maintain Dental Safety Net see page 20
5. Sustain Oral Health Workforce see page 22
6. Inform Oral Health Policy Decisions see page 28

OUTCOMES

Proximal

Barriers between Rhode Islanders and oral health services removed.

Evidence-based science and best practices effectively applied.

A comprehensive oral disease prevention and health promotion system developed.

A strong oral health safety net infrastructure assured.

An adequate and effective oral health workforce assured.

Adequate and appropriate information made available for effective policy decisions.

Distal

Optimal oral health for all Rhode Islanders.

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