Oral Health of Iowa Children
Environmental Scan, 2005

Iowa Department of Public Health
Oral Health Bureau

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Introduction

The purpose of this environmental scan is to identify strengths, weaknesses, trends, and conditions regarding the oral health of Iowa's children. Sources of information for this scan include: Medicaid data, oral health survey data, school-based sealant program data, public health dental hygienist services data, oral health program summaries, needs assessments, and input from forums held around the state.

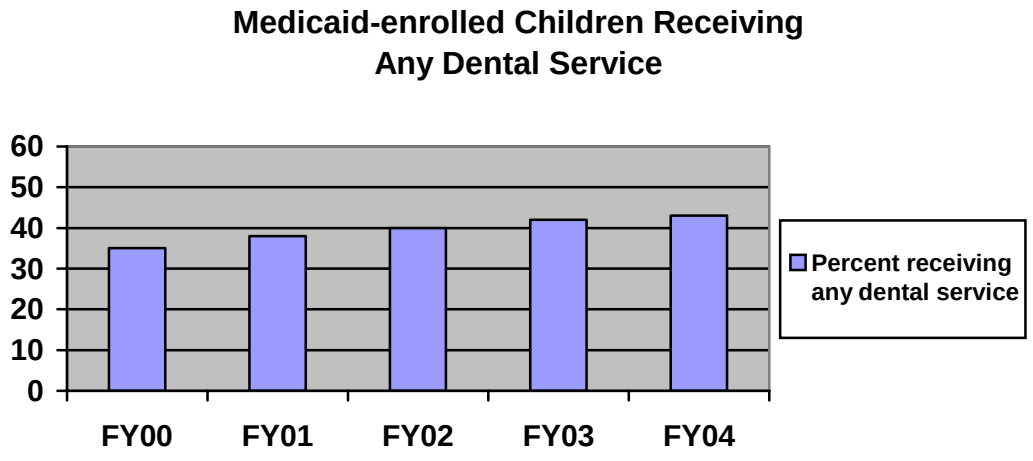
This scan will provide the basis for the Iowa Department of Public Health's Oral Health Bureau to develop a request for proposal for pilot projects to improve access to oral health care within at least two Iowa communities.

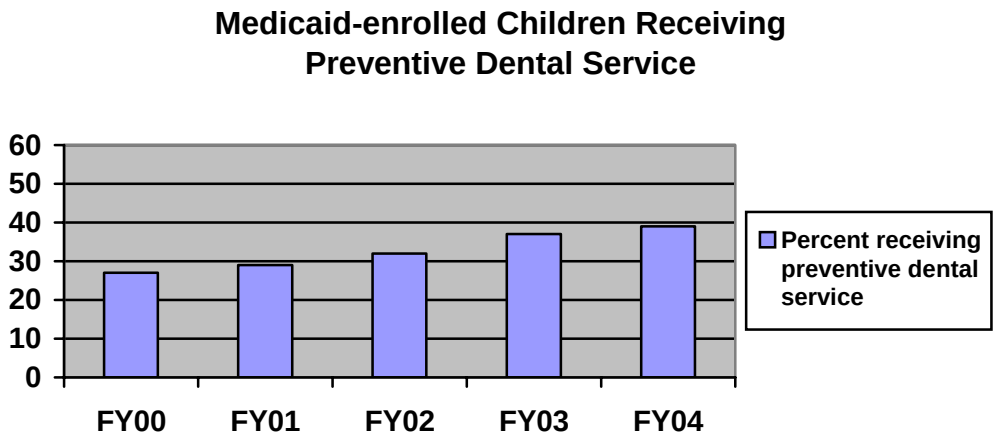
Medicaid Data

Assessing the percent of Medicaid-enrolled children who receive dental services is one method of determining the ability of at-risk populations to access dental care. The Centers for Medicare and Medicaid Services (CMS) 4.16 report is shared with the Iowa Department of Public Health (IDPH) each year.

- *Children ages 1-20*

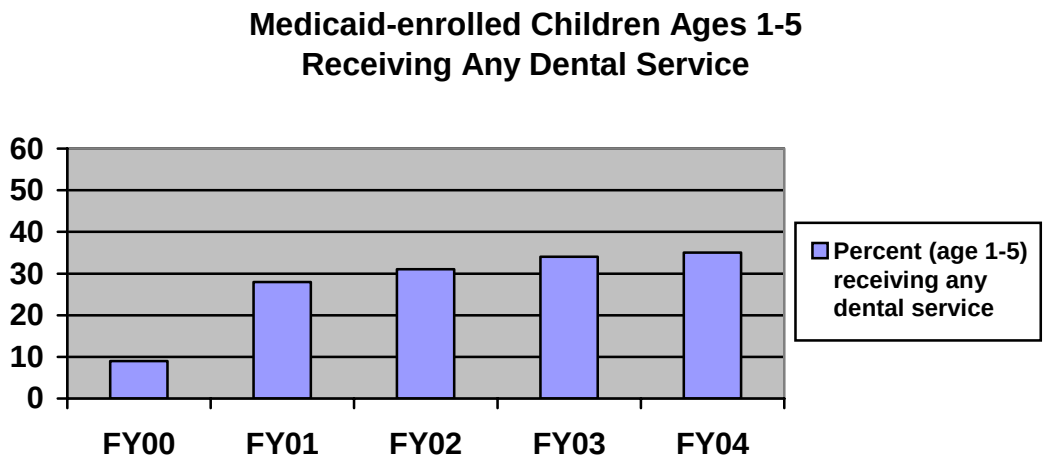
Within the CMS 4.16 report, the (duplicated) number and percent of Medicaid-enrolled children accessing dental services is measured in three ways. The number of children who receive any dental service includes all enrolled children who had at least one dental service billed to Medicaid. The number of children who receive preventive dental services includes all enrolled children who had at least one preventive service (e.g. dental cleaning, fluoride application, or sealant application) billed to Medicaid. The number of children who receive dental treatment includes the enrolled children who had at least one treatment service (e.g. filling, crown, extraction) billed. For the purpose of this scan, we will look at the percent of children receiving any dental service and the percent of children receiving preventive dental services.





- *Children ages 1-5*

Early preventive care, education, and regular dental visits at or by the age of one are crucial for good oral health, especially for at-risk children. Another measurement of particular interest is the percent of Medicaid-enrolled children ages 1-5 that received dental services.

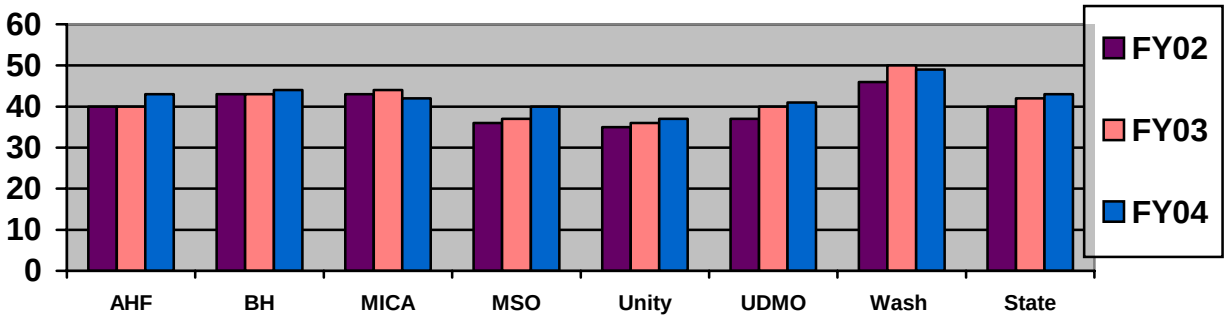


The number of Medicaid-enrolled receiving dental services has risen each year, including services for children ages one through five. The possible reasons for the increases will be discussed within the summary.

School-based Dental Sealant Programs

The Iowa Department of Public Health (IDPH) funds seven school-based dental sealant programs. Medicaid rates for children receiving dental services within the sealant program service areas are fairly similar to the state averages, with the exception of one contractor whose rates are higher. However, the increase in the number of children receiving dental services in at least four of those programs has risen much more dramatically than the state average. This is probably due to not only the provision of exams and sealants, but also because of the increased identification and referral of children with additional treatment needs. The graph below looks at the past three year's rates of the IDPH-funded sealant programs.

Percent of Medicaid-enrolled Children Receiving Any Dental Service in School-based Sealant Program Service Areas

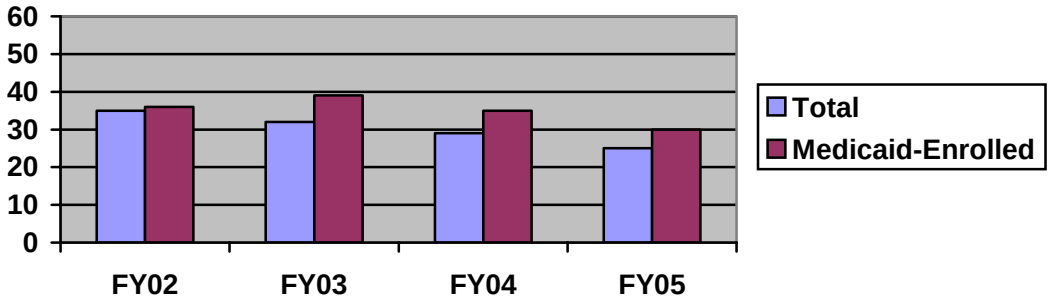


Since FY2001, the IDPH-funded school-based sealant programs have collected standardized data, submitted to IDPH monthly. The following tables show the trends for children participating in the sealant program for untreated decay, history of decay (includes filled teeth and untreated decay), and payment sources for dental care.

- *Untreated Decay*

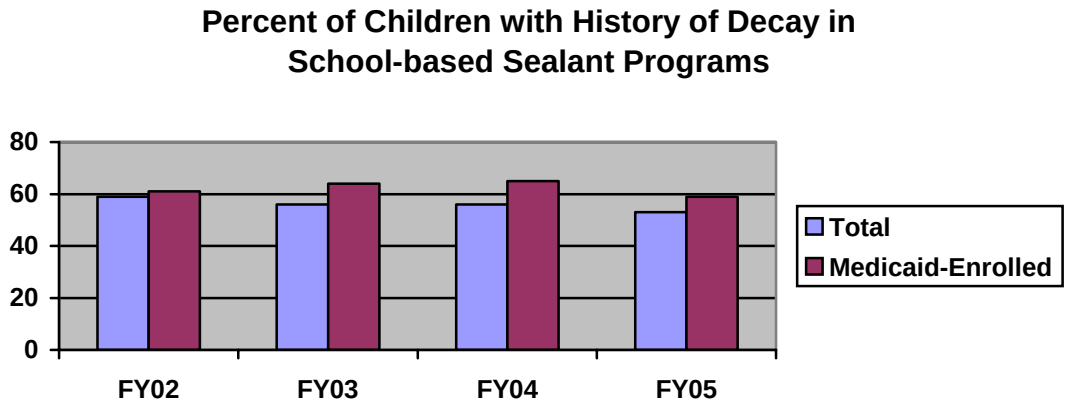
The percent of children enrolled in Medicaid with untreated decay has consistently been higher than the overall percent of children with untreated decay. Of particular interest is that the percent of children with untreated decay, both Medicaid-enrolled and overall, has decreased over the years.

Percent of Children with Untreated Decay in School-based Sealant Programs



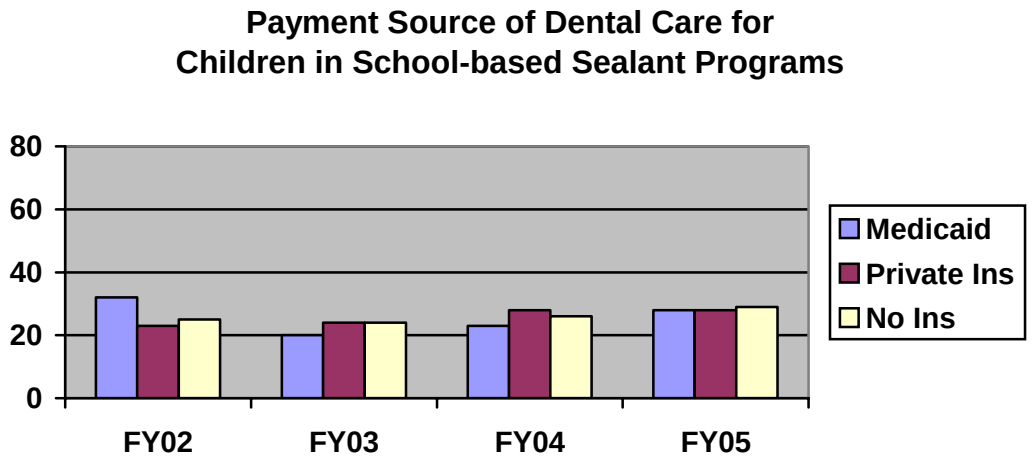
- *History of Decay*

The percent of Medicaid-enrolled children with a history of decay (filled teeth and/or untreated decay) is higher than the overall percent of children with a history of decay. The rates have not seen much change over the past four years.



- *Payment Source of Dental Care*

While the breakdown of payment source for dental care has remained fairy consistent, the number of children without dental insurance has risen. In comparison, the number with private insurance has decreased.



Iowa Access to Baby and Child Dentistry (ABCD) Program

In an effort to strengthen the ability of local communities to improve oral health care for underserved children, the Iowa Access to Baby and Child Dentistry (ABCD) program was initiated in 1999. The goals of the ABCD program are to increase the capacity of communities to provide preventive oral health services, increase access to oral health services, and improve the oral health status of low-income children.

IDPH awards $50,000 annually in ABCD funds to Title V child health agencies. Between FY2000-2002, four pilot projects, two urban and two rural, were funded through competitive grant processes. Each of the four pilot sites received $25,000 per year for two-year project periods to implement state-specific objectives.

Following initial funding, all four ABCD pilot sites have shown a consistent improvement each year in the number of children receiving dental services through Medicaid. Increases in these Medicaid rates range from 11 percent to as much as 20 percent for the agency averages, significantly higher than the overall state increase of 7 percent for that same time period. The table below shows the rates for the pilot sites, as well as the overall state rate since FY1999.

ABCD Pilot Projects
Percent of Medicaid-enrolled children receiving any dental service

Projects	FY99	FY00	FY01	FY02	FY03	FY04
Dubuque VNA	43%	51%	56%	58%	60%	60%
NICAO	36%	41%	44%	46%	47%	50%
MICA	30%	31%	32%	41%	40%	41%
WCPH	29%	27%	43%	46%	50%	49%
State Average	36%	35%	38%	40%	42%	43%

Source: CMS 4.16

Due to the success of the pilot programs, the ABCD program was expanded in FY2003, with funding available to all Title V child health agencies. During FY2005, 21 Title V agencies serving 83 counties implemented ABCD projects. In FY2006, the ABCD program will serve all of Iowa's 99 counties. Funding is allocated according to the proportion of Medicaid-enrolled children per county in each agency's service area. Based on community needs assessments, agencies develop individualized ABCD action plans.

Because the primary focus of ABCD is infrastructure building, measuring the success of the ABCD program can be difficult and must often rely on reporting of activities completed. Some of these activities include: initiation of oral health coalitions, resulting in new community partnerships between public health, private providers, childcare, WIC, Head Start, and schools; heightened interest in local oral health issues through information presented to boards of health, Empowerment boards, and other service agencies; more dental hygienists now active in public health, providing screenings and

fluoride varnish applications to low-income children and offering expertise to assist with dental referrals and patient follow-up; and more dentists are aware of the needs of children in their communities and are working with local Title V agencies to assure care for children.

In 2005, ABCD contractors were asked to respond to four questions when completing their year-end progress reports. The questions and some of the responses are provided below.

Do new community collaborations and/or resources exist due to the ABCD project?

The overwhelming response to this question is "yes", specifically:

- Improvements in the referral process from Head Start, Child Care Nurse Consultants, and school nurses;
- Improved collaboration and "closer link" with local dental practices;
- New collaboration with medical providers;
- Medical clinics beginning to see Title V as a partner in oral health projects;
- New collaboration with Child Care Resource and Referral;
- Increased and improved collaboration with Head Start and Early Head Start;
- Participation in a Volunteer Care Network for dental providers; and
- Efforts of community volunteers and organizations have made great progress in addressing oral health disparities.

Has the ABCD project had an impact on the number of dental providers treating Medicaid-enrolled and low-income children?

About one-third of agencies responded "yes", specifically:

- The number of providers has remained stable and for the most part, adequate;
- New dentists will accept referrals, cultivated by dental outreach efforts;
- Dentists in two counties have agreed to accept Head Start children following screenings by agency dental hygienists;
- The number of dental providers accepting referrals remains fluid;
- Volunteer care network allows local dentists an organized outlet to provide services for low-income children; and
- Local dentists are more willing to examine and provide minor treatment following screenings by agency dental hygienist.

Has the ABCD project had an impact on the number of Medicaid-enrolled and low-income children completing dental referrals?

Most agencies report an increase in the number of children completing referrals, specifically:

- The care coordination process has improved this by making parents aware of their children's dental needs as well as assisting them to make and keep appointments;
- It has increased the number of pregnant women who seek a dental referral and also had an impact on the number of children completing a referral;
- Children may not have received care coordination without the ABCD project;
- Exposing children to oral health education and their first screen/fluoride varnish makes them excited about seeing a dentist;
- Parents have accurate information about appropriate dental care and resources; and
- It has allowed us to make in-roads with local dentists and have access to more dentists for referrals when the need is immediate.

Describe how increased ABCD funding would impact your ability to improve access to dental care for Medicaid-enrolled and low-income children in your service area.

- Perform more care coordination at a greater intensity;
- Use the hygienist more for outreach to dentists;
- Assist us in allowing care coordination to be provided;
- Improve our care coordination system to track referrals and follow-up;
- Allow for staff time to provide additional outreach to dentists;
- Increase time available for follow-up on referrals;
- Promote outreach efforts and help with recruiting volunteers to serve on an oral health coalition;
- Marketing to increase community awareness;
- Contact more children through schools, day care centers and medical providers;
- Hire a hygienist to work with dentists;
- Provide outreach to emphasize importance of oral health;
- Enable community collaboration to keep them involved;
- Increased education; and
- Include more day cares for education and screening preventive programs.

As longitudinal data become available for the statewide ABCD projects, IDPH looks forward to similar Medicaid rate increases as have occurred for the four pilot projects. However, the amount of funds available for those projects may result in a more limited impact.

Services Reports – Public Health Supervision of Dental Hygienists

In 2003, the Iowa Board of Dental Examiners approved a scope of practice rule change allowing "public health supervision" of a dental hygienist. A dental hygienist may enter into a collaborative agreement with a dentist, permitting the hygienist to perform preventive procedures in a public health setting prior to a client seeing a dentist for an exam. The Oral Health Bureau (OHB) is responsible for collecting annual reports from the dental hygienists working under public health supervision.

Data collection from the first year of services (2004) indicates that 12 dental hygienists, working under agreements with 10 dentists, provided over 29,000 services. Over 15,000 children received a service, including oral screenings, fluoride applications, sealants, and/or prophylaxes. Over 11,000 oral screenings and over 1,900 fluoride varnish applications were provided. The goal of the change was to extend the available dental workforce to increase dental care access to underserved Iowa children.

Services Provided by Dental Hygienists
Working Through Public Health Supervision, 2004

SERVICE PROVIDED	TOTAL NUMBER PROVIDED	TOTAL CLIENTS SERVED AGES 0 -20	TOTAL CLIENTS SERVED AGES 21+
SEALANT	10,476	3,185	0
PROPHYLAXIS	157	72	85
ASSESSMENT/ SCREENING	11,472	10,937	251
FLUORIDE VARNISH APPLICATION	1,939	1,567	66
REFERRAL TO DENTIST(S)	3,229	2,866	246
EDUCATIONAL SERVICE	5,143	4,784	241

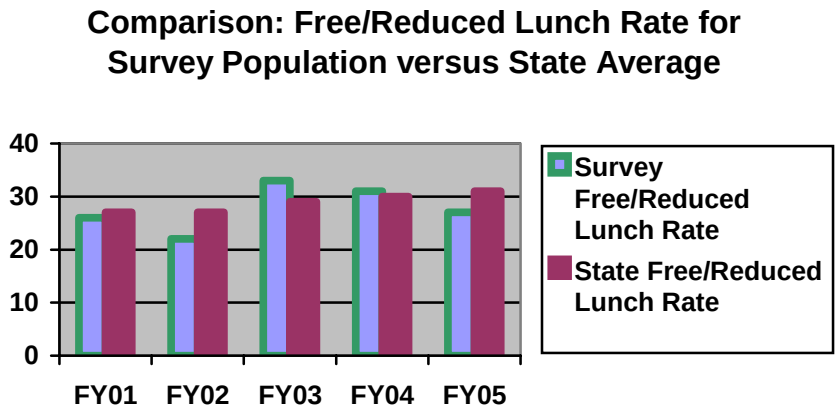
Source: IDPH records

Sealant Prevalence/ Oral Health Surveys:

For the past seven years, the Oral Health Bureau has organized open mouth surveys on 3rd grade children. The first six surveys were targeted at determining the number of third graders with a sealant on a permanent molar. The most recent survey in FY2005 included information on the number of third graders with a cavitated lesion (potential tooth decay) and restored (filled) teeth. The surveys have also collected information regarding the child's payment source for dental care, amount of time since the last dental visit, and participation in the free/reduced lunch program. For this environmental scan, data collected from the FY2001-2005 surveys will be examined.

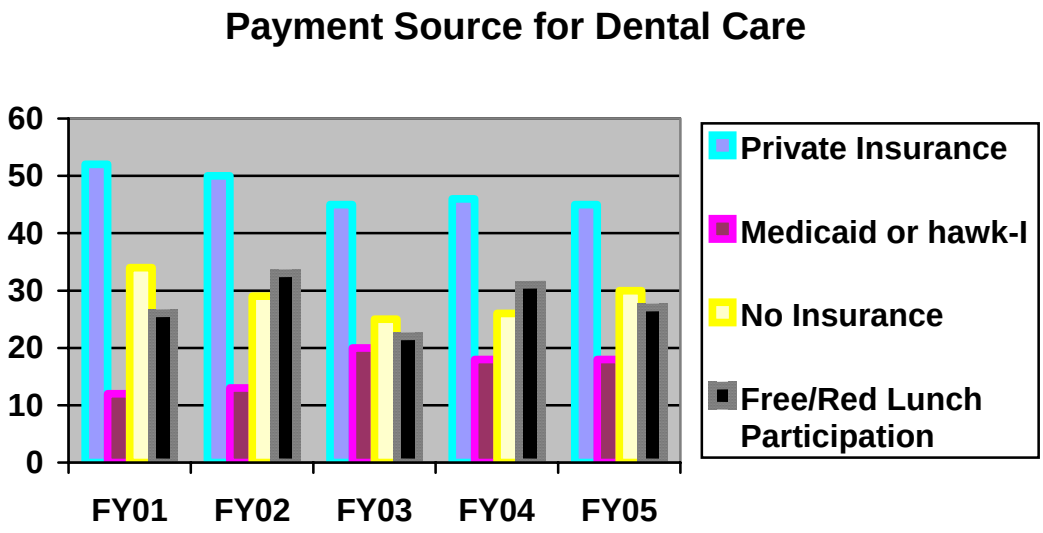
- *Free/Reduced lunch participation*

Since FY2001, the state average of children participating in the free/reduced lunch program has increased about one percent each year (from 27% to 31%). The rate of surveyed children participating in the free/reduced lunch program has varied from a low of 22 percent in FY2002 and a high of 33 percent in FY2003.



- *Payment source for dental care*

The number of children with no dental insurance or those that are enrolled in Medicaid or ***hawk-i*** (Iowa's state children's health insurance program) does not appear to be affected by income, based on a comparison of the number of children without insurance and those participating in the free/reduced lunch program.



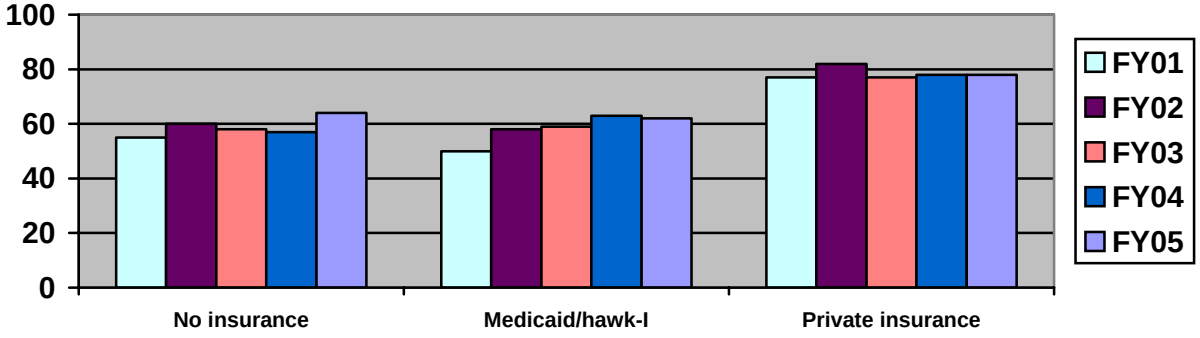
The percent of children enrolled in Medicaid went from a low of 12 percent in FY2001 (when just 21% of children participated in the free/reduced lunch program) to steadily remaining at 18 to 19 percent from FY2003 to FY2005. The percent of children with no dental insurance, however, has ranged from a low of 25 percent to a high of 30 percent in FY2005. At the same time, the percent of children with private insurance has decreased from 52 percent down to 45 percent.

As the number of children with private insurance decreases, there does not appear to be a correlation to an increased number of children enrolled in Medicaid or ***hawk-i***. We would anticipate seeing a relationship, assuming that more families without private insurance may be eligible for Medicaid or ***hawk-i***.

- *Last dental visit*

Survey data also provide a look at the ability of families to access care through the amount of time since a child's last dental visit. While the overall rates have varied from 65 percent to 69 percent, children with private insurance are more likely to have seen a dentist within six months than children with no insurance or using Medicaid or ***hawk-i*** to pay for dental care, as shown in the table below.

Percent of children with a dental visit in the past 6 months, by payment source



Title V Maternal and Child Health (MCH)

IDPH contracts with local public health agencies around the state to assure access to health services for low-income children and pregnant and post-partum women through the Title V Maternal and Child Health (MCH) program. Oral health is an integral component of this system of care. The local agencies assure care through infrastructure-building, population-based, enabling, and some direct care services.

- *Needs Assessment*

In May 2005, applicants for Iowa's community MCH grants were required to include needs assessments within their applications. All MCH applicants identified access to dental care as a need within their service areas. Issues included:

- limited access to pediatric dentists;
- not enough general dentists to serve the population;
- limited access to dental insurance;
- families' lack of understanding of the need for good oral health;
- low Medicaid reimbursement; and
- need for additional preventive services.

Some of the activities that MCH agencies will pursue over the next five-year project period include:

- promotion of dental sealants;
- increased outreach to dental providers;
- oral health education and presentations to parents, health care providers, and children;
- school-based dental sealant programs;
- public service announcements on oral health topics;
- collaboration with local dentists for "Give Kids a Smile" Day;
- provision of screenings and fluoride varnish applications in public health settings; and
- linkages with early childhood stakeholders to promote oral health for children.

- *Title V dental program*

Local Title V child health agencies receive dental funds from IDPH each year. Funds may be used to reimburse dentists for services provided to qualifying child health clients. The table below shows the number of children receiving dental care using Title V dental funds from FY2001-2005.

Federal Fiscal Year	Number of children using Title V dental funds
2001	2,282
2002	2,262
2003	2,107
2004	1,699
2005	940* (* through 3 quarters)

The number of children receiving dental care using Title V dental funds is decreasing; agencies report that more children are qualifying for Medicaid or ***hawk-i*** coverage, decreasing the number needing to use these funds for dental services.

Community Health Needs Assessments and Health Improvement Plans

Local boards of health in all 99 Iowa counties are required to work with county partners to complete a needs assessment and develop a strategic health improvement plan every five years. The Community Health Needs Assessments and Health Improvement Plans (CHNA-HIP) are a source of current county-level data regarding health needs. All counties submitted a CHNA-HIP to the Iowa Department of Public Health (IDPH) in February, 2005.

Fifteen Iowa counties identified oral health as a health issue within their 2005 CHNA-HIP. Issues that were identified included:

- no access to care for elderly;
- high rate of caries history for school children;
- lack of knowledge by the public on need for good oral health;
- fragmentation of services in rural Iowa;
- lack of transportation in rural Iowa;
- large number of dentists retiring and not able to recruit dentists to buy their practices; and
- difficulty finding dentists willing to be responsible for low-income patients' regular care.

Strategies that counties will undertake to improve access to dental care include:

- working with non-profit organizations to create a source of payment for low-income individuals;
- recruitment of dentists;
- providing school-based dental services;
- applying for a community health center dental clinic;
- seeking local financial assistance to promote oral health;
- forming a task group to investigate local issues;
- developing a public awareness campaign;
- implementing regular screenings for children birth to age six;
- providing services to nursing home residents;
- educating physicians on oral health issues; and
- partnering with local businesses and dentists for "Give Kids a Smile" Day.

Regional Oral Health Forums

In the spring of 2005, the Oral Health Bureau held 12 regional meetings around the state. The purpose of the meetings was to gather input from local stakeholders about oral health needs of children and families and community capacity to meet those needs, as well as to hear recommendations on how to best build local capacity and to raise awareness about oral health issues.

Not surprisingly, the issues and potential solutions that bureau staff heard from local stakeholders echo the issues and solutions also listed within Maternal and Child Health (MCH) needs assessments and Community Health Needs Assessments and Health Improvement Plans (CHNA-HIP).

Some of the recurrent issues identified within the forums included: lack of perceived need, lack of providers and/or hours of service, lack of specialized providers, transportation, financial, lack of system integration, cultural barriers, education, and availability of data.

Some of the highlighted issues discussed at the meetings are included below. The information is organized according to the specific forum questions asked of the participants by the forum facilitator.

BARRIERS

Forum discussion question: What are the barriers, if any, preventing optimal oral health for families in your community (family/cultural, school, dental providers, financial, transportation)?

- Not enough dentists
- Lack of perceived need for oral health care
- Payment issues—no insurance or gap-filling resources
- Public health moved out of direct medical care, causing lost continuity between medical and dental services
- Not enough Medicaid providers
- Adult care is lacking
- Low Medicaid reimbursement
- Transportation issues
- Lack of translation services
- No access for children under the age of three
- No programs for the elderly
- Funding limitations
- Missing collaboration with schools

COMMUNITY ASSETS

Forum discussion questions: What is currently being done in your community to promote good oral health for families? What are the assets available in the community to promote good oral health?

- Local dental advisory boards
- Some physicians knowledgeable about oral health
- School-based dental sealant programs
- Free or low-cost dental clinics
- Community health center dental clinics
- Dental hygienists providing screenings, fluoride varnish applications, and care coordination
- Strong community collaboratives
- Some local board of health members are active in improving access to oral health care
- Child care nurse consultants are providing oral health education
- Some transportation assistance
- Special Supplemental Nutrition for Women, Infants, and Children program (WIC) and Head Start have strong oral health focuses
- Healthy Smiles home visitor training project
- More pediatric dentists in the state than six years ago
- Economic development involvement in recruiting dentists
- ***hawk-i*** dental coverage

RECOMMENDATIONS

Forum discussion question: What are possible strategies/interventions to address optimal oral health for families in the community?

- Promote oral health in schools
- Increase the number of dental school graduates from the University of Iowa
- Develop loan repayment programs
- Better care coordination to improve patient compliance
- Improve the link of oral health to overall health
- Improve correspondence between IDPH and private practice dentists (e.g. promoting the benefits of fluoride varnish, importance of seeing children at age one)
- Develop a program for retired dentists to provide public health services
- Increase medical/dental collaboration
- Empower families, do not enable them
- Prevention programs
- Expand scope of practice for dental hygienists

WHAT CAN THE STATE DO?

- Social marketing campaign
- Increase funding for oral health care and programs
- Begin a public health curriculum for medical and dental schools
- Provide continuing education credit for volunteers
- Legislative mandates (e.g. dentists must accept a certain percentage of Medicaid-enrolled patients or require all kindergarteners have a dental exam prior to starting school)
- Increase the number of University of Iowa dental externships and include rural Iowa
- IDPH communications link (e.g. list serve)
- Improve school oral health curriculum—use school nurses as advocates
- Increase Medicaid reimbursement
- Educate all healthcare providers about oral health
- Improve workforce retention and recruitment through economic development, loan repayment, tax incentives

Summary

Iowa data appear to mirror national data. Children from low-income families, with no insurance, and those enrolled in Medicaid tend to have more untreated decay and fewer opportunities for regular dental care.

Although the percent of Medicaid-enrolled children receiving dental services is rising each year, more than 50 percent of Medicaid-enrolled children are not receiving any dental services. What's more, the rates merely reflect the number of children who had at least one service billed to Medicaid. This does not equate to each child having a dental home where they can access regular care. Nevertheless, it is important to consider the potential causes for the positive trend in rates.

Many factors could play a role in the increased Medicaid rates. In 1997, Title V child health agencies became eligible to bill Medicaid for oral screenings provided by dental hygienists by requesting an exception to Medicaid policy. Several agencies began to offer this service, and in 1999 Medicaid also allowed reimbursement for fluoride varnish applications. These services are provided in over one-third of Iowa counties and are now considered standard of care for the Medicaid child health program, no longer requiring an exception to policy.

In addition to direct services, Title V agencies provide outreach and care coordination activities to families that they serve. Through these enabling services, families are educated about the importance of good oral health, assisted with finding payment sources for care, informed about the need for regular care, and assisted in setting up dental appointments. The combination of additional services provided by dental hygienists and improved care coordination and referral efforts likely play a role in improved Medicaid rates.

It is difficult to know if an increase in Medicaid dental fee reimbursement has played a role in the improved rates. Reimbursement rates for dental services were increased to 75 percent of the “usual and customary” rates in 2000 (payment for a comprehensive exam went from $17.95 to $22.31). Although there has not been an increase since, and state budget issues have caused two to three percent increases and decreases at times, the higher reimbursement per service may still be more appealing than the fees paid prior to 2000. Nonetheless, as noted within the oral health forums summary, many dental offices still cite “low reimbursement” as a barrier for accepting Medicaid-enrolled patients, particularly new patients.

Following the fee increases in 2000, the Department of Human Services reports that there was not an increase in providers, but those dentists that already saw Medicaid-enrolled patients tended to provide more services. The number of dentists enrolled as providers with Medicaid has increased from 1,233 in 1999 (78% of licensed dentists) to 1,371 in 2004 (77 % of licensed dentists). Although it appears there are more providers enrolled with Medicaid, there are also more providers overall. Oral health forum participants felt that many dentists see only their current Medicaid patients and do not accept new patients. Forum participants also thought that comprehensive care may be limited, with Medicaid-enrolled patients seen mostly for acute care. Comprehensive care is particularly limited for adults, due to a reduction in Medicaid’s service coverage in 2000.

There is a shortage of dentists overall, particularly in rural Iowa, making access to care difficult for all Iowans. Currently, 71 of Iowa’s 99 counties and a portion of Polk County are designated as dental health professional shortage areas (HPSA). The county HPSA designations are currently undergoing a re-assessment. Preliminary data indicate a potential increase in shortage areas.

Some Iowa communities have been successful in working with local economic development groups to create attractive packages to lure dentists to their area. Incentives have included assistance with rent and loan repayment. The state will need to work with public and private partners to increase these types of opportunities in an effort to attract more dentists to HPSA counties.

The percent of Medicaid-enrolled children ages one through five that receive dental services has been on the increase, likely due to the increase in services provided by dental hygienists in public health, the increased number of pediatric dentists in the state, and new public health programs targeting early childhood. Yet, many dentists are not comfortable providing care for children under the age of three. With the addition of more dental hygienists working in public health providing early prevention for this vulnerable population, families are becoming more aware of the importance of regular care for children beginning at age one. There is a definite need to work with dental providers regarding the importance of seeing children before they reach the age of three, as well as to increase dental students' exposure to pediatric dental cases.

Dental hygienists have been limited in the care they can provide due to supervision and scope of practice issues. However, the new public health supervision rule is impacting this. The numbers reported in the first year of implementation are promising. IDPH anticipates more at-risk Iowans will receive preventive dental services each year, but some hygienists are having difficulty finding dentists willing to provide public health supervision via a collaborative agreement. Ways to market the benefits of public health supervision to the dental community need to be discussed.

To a large degree, Iowa has not pursued the use of non-dental healthcare providers to provide preventive services. The department continues to investigate use of medical professionals as a means of providing primary dental care for children, particularly those under the age of three.

School-based sealant programs have proven to be effective in improving care for children as well as improving oral health infrastructure within a community. Children participating in school-based sealant programs have the advantage of not only receiving preventive sealants, but also being identified with treatment needs and being referred for care. Children without a regular source of care are identified and assisted in finding a dental home. These may be the reasons why there is a trend of less untreated decay within those programs, while the number of children with a history of decay remains steady.

Areas of the state that are having the most success getting children into care are those that have strong community collaboration. Programs such as Access to Baby and Child Dentistry (ABCD) have strengthened community infrastructure, improving the ability to increase access to care. Local Title V agencies provide care coordination and oral health education for families, which are strengthening the knowledge of the importance of good oral health. However, as noted within the ABCD summary, the amount of money allocated for oral health programs is not enough to make as big an impact on children's oral health as is needed.

As reported in the Surgeon General's report, children without dental insurance are more than two times likely not to access care than children with insurance. This is a particular concern when looking at Iowa's data regarding the increasing number of children with no dental insurance and the decreasing number with private insurance. It will be important for the state, as well as local communities, to try to reach families that may qualify for Medicaid or ***hawk-i,*** in addition to increasing gap-filling services to assure care is available.

Information from the Community Health Needs Assessments and Title V Needs Assessments, in addition to discussions at the 12 regional oral health forums proves that communities are aware of the oral health needs of their residents. The insight provided by attendees at the forums is an excellent overview regarding the availability of oral health services for children in Iowa. The barriers and assets identified and the ideas to improve the oral health system that came from the participants are reflected within the additional data sources used for this scan. While the data must be reviewed and considered, the knowledge and views of stakeholders at the local level perhaps provide the best indication of where children's oral health is currently and where it needs to be.

With the use of this information, the Oral Health Bureau will continue to develop new collaborations and design new programs to benefit the children in the state, with an overall goal of further integrating oral health into local public health.

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