Local Health Department Targets Preventive Oral Health

Greg Oliver

The lack of sufficient access to dental care, particularly for lower-income residents, is a challenge in communities throughout the Pacific Northwest. In recent years the Surgeon General's report (2000) identified oral health as a major public health concern; the Centers for Disease Control and Prevention weighed in with many position papers; and Healthy People 2010 identified oral health as one of its 28 topics. National leaders are calling for multifaceted oral health strategies that include much more than simply ensuring that patients in pain find their way to dentists' chairs.

What can and should strapped local health departments do about oral health, particularly when there is no new funding? The experience of Missoula City-County Health Department (MCCHD) offers some insight on how to arrive at successful policy and program change.

The Department got involved in oral health when deciding whether to fluoridate the community water supply. Although the question of fluoridation is still undecided, as a result of contending with the pros and cons of the issue, MCCHD and stakeholders learned about additional promising strategies that would be necessary whether the water was fluoridated or not.

When a local health department has no new funds, it must be creative and efficient in addressing new concerns.

Background

In the mid 1990s, the Missoula City-County Health Board became increasingly aware of residents suffering from oral health disease and helped the Partnership Health Center (PHC), which is part of MCCHD, add dental care to its services. Initially, PHC used a few volunteer dentists; eventually the program evolved, the waiting list for dental care grew, and they hired a halftime dentist. This step attracted the resistance of several dentists who threatened litigation and lobbied against the program at the state level.

At a crowded and emotional public hearing in April 2000, the Health Board heard from dozens of citizens, human service agencies, pediatricians, and emergency room physicians. It listened to convincing testimony that untreated, late-stage oral disease was a substantial problem for low-income citizens. Person after person testified, with many sharing horror stories of untreated pain and suffering.

The testimony moved the board, and particularly Dr. Hal Braun, a long-standing board member and retired cardiologist. His interest was sparked when dentists testified that "most of this suffering is preventable; dental caries is the chief culprit, and community water fluoridation is the cornerstone of caries prevention." Dr. Braun took the comment to heart, in part because he was looking for a way to work with the dentists as partners instead of enemies. In March 2001, at a strategic planning retreat, the board identified oral health as a high priority.

Inclusive partnerships

Dr. Braun asked the board to form a study group to research the relative merits and feasibility of community water fluoridation. He recruited several people to join him, including a dentist and a representative from the privately owned water company.

MCCHD staffed the Fluoridation Study Group, which met for many months and reviewed the abundant material available on fluoridation. It noted that scores of important professional organizations, including the Centers for Disease Control and Prevention, the Surgeon General, and the American Medical Association, were unequivocally in favor of all drinking water having an appropriate level of fluoride. But the committee also recognized many caveats.

Missoula County has a population of 95,800, half of whom are served by a privately owned water company. The rest are served by small systems or private wells and would not have a fluoridated supply.

- The water company did not want to fluoridate and had their lawyer respond with a daunting list of conditions regarding what it might take to make them do so.
- City and county attorneys were not sure if Montana law gave local government the power to compel a privately owned water system to fluoridate.
- Several recent regional attempts at water fluoridation have included community battles, expensive campaigns, and ballot initiatives, and many have failed (e.g., Spokane, Washington). MCCHD had no funds to coordinate a full-fledged campaign.

- Some evidence suggests that the relative improvement in reduction of dental caries resulting from fluoridated water supplies is less now due to fluoride toothpaste and the presence of fluoride in more products.

In fall 2001, the Fluoridation Study Group presented its findings to the board. Although it recommended that the board pursue community water fluoridation, it emphasized that Missoula needed to consider additional strategies as well, because fluoridation was not the magic bullet the Board had hoped for. The group recommended that the board appoint a broad-based Preventive Oral Health Advisory Committee (POHAC) to develop a set of practical recommendations about what Missoula should do in the next two years. It also recommended focusing on children's oral health.

At this point, because of the work of the study group, the Health Department identified and pursued a small grant to support POHAC work over the next five months. The board appointed a group of stakeholder representatives (two board members, two dentists, a dental hygienist, a pediatrician, a school nurse, the WIC director, the Head Start director, and an anti-fluoridation nonprofit leader) who met once a month as a full group and also worked on subcommittee teams exploring different issues and reporting back to the group.

Since they were an official subcommittee of the board and had a formal time-limited charge and a clear goal, members attended regularly. The subcommittee consulted with the local dental association three times, arranged meetings with individual dentist leaders, and sent two direct mailings to all dentists in the county. It also developed three major newspaper stories.

They produced a special Missoula Measures report on children's oral health that unequivocally described the need for action. They also contacted eight Peer Communities in the western states to see how they responded to oral health concerns. (*See the Peer Communities Web site at www.co.missoula.mt.us/measures/peers.htm.*) In April 2002, POHAC produced a final report with specific steps associated with seven objectives:

1. Increase the number of children with unmet dental needs who receive dental care
2. Increase utilization of effective oral health products and services
3. Implement effective outreach/marketing to parents
4. Enhance education in elementary school settings
5. Improve the nutritional content of foods and beverages offered to students through vending machines in Missoula high schools
6. Add fluoride to community water supply
7. Build community capacity to pursue the POHAC recommendations

Working with what's available

The effect of the work on preventive oral health was subtle but paved the way for some significant change. It also positioned MCCHD strongly for constructive future work and possible grant funding. Positive outcomes included:

- The board acknowledged dentists as valuable partners and conscientiously pursued several of their recommendations. Documentation that 5,000 Medicaid children were unable to be seen by a dentist and that dentists did not want to change their practice significantly helped reduce dentists' resistance to more public dental care.
- PHC found funding to add another dental chair, recruit a hygienist, and enhance the public dentist from halftime to full-time without resistance from other dentists.
- By transferring leadership on this issue to the board and POHAC, the vilified PHC director was able to proceed much more effectively.
- The school district that serves more than half the county's children made changes in elementary oral health procedures, largely because their school nurse was part of POHAC.
- The Health Department found partners who were interested in changing vending machine policies at high schools and recently received a grant targeting obesity that will support oral health efforts.
- The Health Department learned that it can rent a dental van owned on the other side of the state (making the project affordable) and pilot an outreach effort at several elementary schools with the most low-income children, including the Head Start program.
- The process has clarified objectives and demonstrated community commitment for subsequent grant opportunities.

The Department's experience with the oral health initiative has underscored two points. First, when a local health department has no new funds, it must be creative and efficient in addressing new concerns. The process needs to be credible and inclusive, but it also must be manageable and not set up too many expectations that the department can't meet.

Second, changing informal and formal policies is not as expensive as developing and sustaining programs. Helping partners understand what is in place in a community, and looking for ways that each can do a little more or do things a little differently, can add up to big gains.

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Author

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