Northern Virginia Oral Health Forum

Presented by the Virginia Oral Health Coalition

With generous support from the Northern Virginia Health Foundation and Potomac Health Foundation

Thursday, January 26, 2017 | 9:30 a.m. – 2:00 p.m.

Sheraton Tysons Hotel | 8661 Leesburg Pike, Tysons, VA 22182

Meeting Facilitator: Kathy Greenier, Floricane, LLC

Proceedings

Meeting facilitator Kathy Greenier led introductions at tables.

Welcome

Susie Lee, Executive Director, Potomac Health Foundation & Pat Mathews, President & CEO at the Northern Virginia Health Foundation

Overview of the 2016 Virginia Oral Health Report Card

Sarah Bedard Holland, Executive Director, Virginia Oral Health Coalition

- Click to download a copy of Sarah's presentation slides.

Data Walk Activity

- Kathy invited participants to break into groups of three and provided instructions for the Data Walk activity.
- Half of the groups viewed posters representing adult oral health data, and half of the groups reviewed posters representing children oral health data, then switched.
- Each group appointed a scribe to record their responses to a set of question prompts about the data as they viewed the posters.
- Click to download a handout of the charts that participants reviewed during the data walk.
- Click to download a detailed compilation of the participants' responses.
- Summary of participants' responses:
    - Overall
        - More granular regional and local data is needed, especially on barriers to care such as transportation, time, employment, language, immigration status, etc.
        - Demographics such as race/ethnicity, SES, gender, age, etc. should be consistently reported
        - Need to know all data characteristics – e.g., indicator description, time frame, sample size, sample weights, statistical power, and significance of within-/between-group differences

        - Inferences about causal relationships cannot be made based on the charts presented; they only show descriptive statistics, leaving a lot of possible interpretations. More complex analyses may be needed.
        - Helpful to know how the region compares to other regions, the state, and the nation
        - Several populations were missing or underrepresented; e.g., some racial/ethnic groups, individuals with special health care needs, etc.
    - Adult Oral Health Indicators
        - Many were surprised by specific data points, such as
            - the high number of older adults (65+) who had a dental visit (seemed to be contrary to the low % of adults who are actually covered)
            - the apparent correlation between low income and greater effects of dental pain
            - the limited race/ethnicity data for the adult indicators generally
        - Most agreed that the data gave only a cursory snapshot of the health inequities in Northern Virginia
            - Data specific to cultural perspectives of dental care was lacking
    - Children Oral Health Indicators
        - Again, many were surprised by specific data points, such as
            - low preventive service utilization among eligible children of all races/ethnicities and ages
            - differences by age among 3rd grade children in decay and sealant rates
            - the apparent disparities in 3rd grade sealant rates and prevalence of tooth decay when broken out by race/ethnicity, SES, and coverage status
        - Most agreed that the data gave only a cursory snapshot of the health inequities in Northern Virginia
            - Even children with Medicaid coverage have low utilization
            - Data specific to cultural perspectives of dental care was lacking
        - Many were curious about the timing of interventions and their effects on outcomes shown in the data, especially sealants and decay rates

Data Walk Debrief

Following the data walk, participants had a large group debrief, facilitated by Kathy Greenier.

"L" refers to Lauren Gray, VaOHC Program & Engagement Manager, and "A" refers to an attendee:

- Is there a way to work with the data to determine if the differences are statistically significant? I.e. are the differences meaningful?
    - L: Most of the survey data comes from VDH, and yes, it is possible to examine significant differences between groups and overall – but, when aggregated regionally, the samples for this data may be too small to test the statistical significance. If there are questions, please write them down and send them to the Coalition. Part of the reason we're here today is to figure out the questions and gaps to lift those up to state partners. With the Medicaid utilization data, we do not have the capacity to analyze statistical significance.
- Can you determine whether the outcomes are mediated/moderated by race vs. SES?
    - L: Challenge with national- or state-level surveys is that they're aggregated best and most precisely at the state level rather than regionally (limited for a representative sample within the region). It's still good to have the information, but going forward as we're working in the oral health and social determinants/health equity, we need to be defining the groups more clearly to determine if the differences we see really are along racial/ethnic lines or SES lines.
- Attendee: Additional demographic data would inform the strategies; e.g. If Spanish isn't first language, would have Spanish language materials
- With all of the charts, need more context – where does oral health fit in the state's strategic plan and as a priority?
    - Sarah: We have a state oral health plan, and the Coalition convenes population-focused, state-level workgroups. We also work to align the plan with other agency plans where they overlap. However, we don't know about all of the regional plans that exist, strategies, etc. - we don't know how they marry and it's a great strategic point to talk about today.
    - A: Alexandria strategic plan lists local health concerns – equally as important for the city where the state puts the health issues.
- Charts in jurisdiction didn't include Loudoun.
    - L: Particularly the adult data from BRFSS – it's from health planning region
- White/Hispanic isn't included
    - L: There wasn't a large enough sample size to be able to break it by every race; ones listed are the only ones large enough. Some of the data is weighted to reflect the size of the population. Show the demographic breakdown for the region in the future. Depends on the survey, but moving forward we will show what is weighted (like BRFSS).
- Who performs 3rd grade screening?
    - L: VDH has public health dental hygienists who perform open mouth surveys and clinical services all over the state. Is a representative sample.
- Why is there a difference in age in the 3rd grade?

    - L: Different reasons for age differences for each region. Children from other countries may be older. Statewide, % of 10 year olds is very small in terms of sample size.
- Is data 3rd graders who have gotten sealants in kindergarten or for the first time in 3rd grade? Can we tell when the intervention is happening?
    - L: We can look and see if they have notes about the timing of sealants.
    - Browder (VDH): Follows guidance from the CDC – statewide survey of schools, weighted, prevalence only – when and where they were done isn't gathered. Has to do with the likelihood that they'd have 6 year molars and practical matter of conducting the survey.
- Can someone from schools tell us when sealants are offered?
    - Most commonly kindergarten and first grade (5 or 6).
    - Browder (VDH): VDH is the bigger of all school programs, but more programs around the state. VDH sees kids for an assessment, can do fluoride varnish for younger children. If kids have molars in kindergarten, they would seal it. 10 hygienists in dental HPSAs categories, then schools are identified by free lunch participation, then principals give permission, then parents give permission.

Population Group Discussions

Raja'a Satouri (Fairfax County Health Department) introduced the afternoon activity, and Kathy gave the instructions. Meeting attendees assigned themselves to different groups by population category: adults, children, individuals with special health care needs, and older adults. Each group responded to a set of two question prompts. The responses are summarized below for each population group.

<u>Prompt 1</u>

Taking into account the regional snapshot you saw, the context of your work and experience, relevant health indicators, and the unique needs of your population:

1. **Identify one priority issue that, when addressed, will improve the system of health care and create enduring change for your population. E.g., "Increasing the sealant rate among Northern Virginia's Hispanic third grade children."**

2. **Frame that issue as an outcome statement; e.g., "By 2022, the sealant rate among Northern Virginia's Hispanic third grade children will improve by 5%."**

Adult group	By 2020 % of pregnant women receiving dental services increases by 5%.
Children group 1	Identified a few priorities: • Oral health education of children and parents • Every child should have a dental home and identified provider

	• School systems monitoring students' dental visits
Children group 2	1. PCPs are not checking dental screening on MCH 213 (VA School Entrance Health Form) – in Alexandria Public Schools (ACPS) <50% checked; educating health care professionals about importance of dental health. 2. By 2020 there will be a 20-30% increase in documentation of dental screening on kindergarten entrance physicals (MCH 213s), bringing attention to health care professionals, awareness, handouts.
Children group 3	1. To increase the number of children who have identified dental home by age 1. 2. By 2022, the number of 1-year old children who have an identified dental home will improve by 25%.
Individuals with special health care needs (ISHCN)	1. Barriers: • Transportation • Payment procedure • Accessibility • Dental providers limited education about ISHCN and bias • Lack of monetary resources • Inter-professional care coordination • Education for the population/advocates • Advocates may be too few and may not have broad enough expertise in what are the varying needs for ISHCN to collaborate • ISHCN may be afraid to identify themselves – need to feel empowered, dignified 2. By 2020, an inter-health professional curriculum on ISHCN will be established and taught at the college level (or professional school).
Older adults	1. Expand oral health data collection on older adults, especially those residing in long-term care (LTC) facilities. It must be noted that, even with the "aging in place" strategy, LTC and nursing home population is not declining; some can't live at home. There are likely major disparities by race/ethnicity, SES, etc. 2. By 2022, increase the rate of LTC residents accessing dental care by X% (need baseline data).

Prompt 2

Building on the priority you have been discussing, answer the following questions together:

3. **What is already happening in Northern Virginia to address this?**

4. **What is missing? If nothing is currently happening in this region, what examples elsewhere might inform our work?**

5. **Identify 1 or 2 high-level strategies that address the barriers surrounding the priority you identified. These strategies can build on existing efforts identified in question 3, or they can fill gaps addressed in question 4. E.g., "Change school district policy to facilitate expansion of sealant programs."**

Adult group	3. Case workers, home visitors, pharmacy, and health care navigators. 4. Several gaps: • Oral health integration – involvement and education of primary care and OB/GYN providers • Awareness about the relationship between oral health and overall health (oral health literacy), and the existence of the Medicaid dental benefit for pregnant women (and what it covers) • Navigation systems to access care (transportation, understanding social determinants, and access) • Coordinated charity care 5. Three strategies: • Strategy 1 – Provider education: o Address abandonment and legality (no waiver) o OBGYN education • Strategy 2 – Navigation: o DSS – include an oral health component in training o Use patient navigators – Community Dental Health Coordinator (CDHC) model promoted by American Dental Association. o Social workers/home visitors • Strategy 3 – Consumer education o Messaging and different tactics
Children group 1	Oral health education of children and parents • Dietary components – sugar intake • When to brush • 6 months old begin dental care Every child should have a dental home and identified provider • Dental professionals visit schools – what info do they share? • Could OB/GYNs play a role in increasing parents' awareness of the need for preventive dental care and healthy eating habits to prevent cavities? School systems monitoring students' dental care • Could require children to brush their teeth after lunch at school – maybe a targeted intervention for Head Start students • School health forms offer an opportunity to gather data about kids' connection to dentists
Children group 2	3. ACPS, Neighborhood Health mobile van

	4. Nothing is currently being done to educate health care providers (like pediatricians, etc.) to do dental screenings and refer as needed. 5. Eight main strategies: • Education of all health care providers • Ask National Association of School Nurses (NASN) to add oral health to chronic health conditions to collect data • Can MCH 213 be reviewed to include dental screenings? • Recommended training website- VDH could send out • WIC screening in • Food banks – toothbrush • Backpacks stuffed with toothbrushes, toothpaste, resources • Social media
Children group 3	3. Bright Smiles, Smiles for Children, family services, early childhood programs (Early Head Start & Head Start), pediatric dental offices taking Medicaid 4. Partnerships between PCPs and pediatric dentists, culturally relevant dental education, safety net programs – missing comp. list 5. Education: • Health care provider education – OB/GYN offices, PCPs, etc. • Education targeting patients at these offices
ISHCNs	3. What's happening: • There are professionals currently working with ISHCN that have expertise • Tufts is working on a special curriculum re: kids with ISHCN • Our response to those with ISHCN is currently reactive 4. What's not happening: • Various groups not working together • Lack of clarity around who makes existing curricula • Our response to ISHCNs is not proactive 5. A curriculum is not a plan, it's part of a plan. With that said, the top 2 strategies to implement this curriculum would be: • Make compassion a value in our society • Need a list of other curricular that's out there now
Older adults	3. Arlington data, treatment plans, some major issues known 4. Need to determine barriers, emergent needs, utilization, edentulism rates 5. Three main strategies: • Identify greater needs through qualitative data, include data broken out by race • Improve partnerships with community organizations • Utilize remote dental hygiene or other remote care models

Closing Remarks

Sarah (VaOHC) thanked attendees and reminded everyone that meeting materials (including handouts and powerpoints) will be shared after the meeting.

Sarah encouraged attendees to fill out a partnership form to get involved with the Northern Virginia Oral Health Steering Committee, and/or one of VaOHC's state-level workgroups.

Next Meeting – Northern Virginia Oral Health Steering Committee

Thursday, April 6, 12:30 pm – 2:30 pm
Northern Virginia Family Service
10455 White Granite Drive
Suite 100 – Oakton Training Room
Oakton, VA 22124

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Meeting Facilitator: Kathy Greenier, Floricane, LLC

Agenda

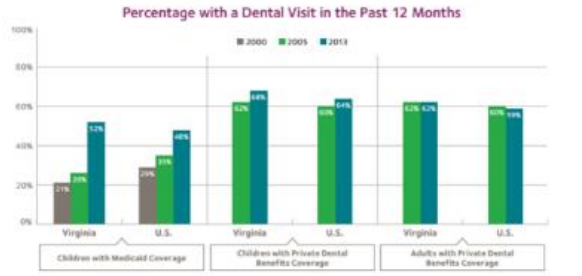
9:30 am – 10:00 am	**Check-in begins**
10:00 am – 10:20 am	**Welcome & Introductions** Kathy Greenier, Floricane, LLC Susie Lee, Executive Director, Potomac Health Foundation Pat Mathews, President and CEO, Northern Virginia Health Foundation
10:20 am – 10:40 am	**Overview of the Virginia Oral Health Report Card 2016** Sarah Holland, Executive Director, Virginia Oral Health Coalition
10:40 am – 11:25 am	**Data Walk: Examining Oral Health in Northern Virginia with a Health Equity Lens**
11:25 am – 11:40 am	**Data Walk Debrief**
11:40 am – 12:30 pm	**Lunch (Provided)**
12:30 pm – 1:50 pm	**Population Group Discussions** Introduction by Raja'a Satouri, MD, Deputy Director for Medical Services, Fairfax County Health Department
1:50 pm – 2:00 pm	**Closing Remarks** Sarah Holland, Executive Director, Virginia Oral Health Coalition

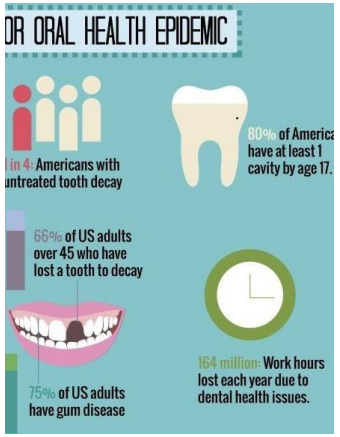
This forum is presented by the Virginia Oral Health Coalition (VaOHC). For more information about VaOHC visit www.vaoralhealth.org. Additional funding support provided by Smile Virginia and DentaQuest, LLC.

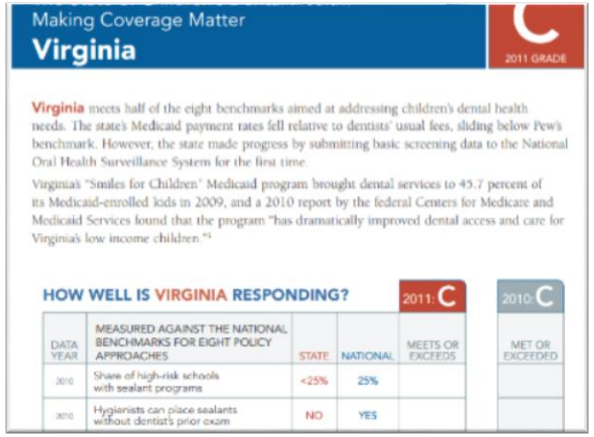
Virginia Oral Health Report Card

WHY, WHO, HOW, WHAT, WHAT NOW??


Virginia Oral Health
REPORT
CARD







What?

Simple, easy to understand, data-based visual that provides a snapshot of oral health in the state and a path to improvement

Why a Report Card?

Raise public awareness

Measure Progress

Align Efforts

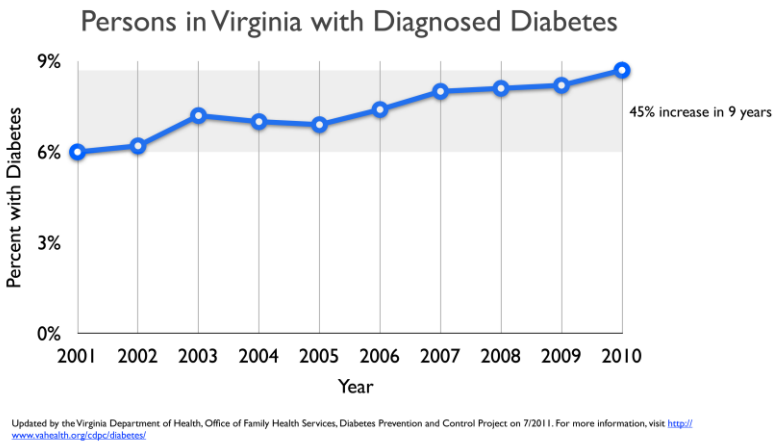
Identify Needs and Gaps

Highlight Disparities

Identify Success

Stimulate Change

Foster Collaboration



Who

Safety Net

State Agency Partners (VDH, DBHDS, DOE, DMAS)

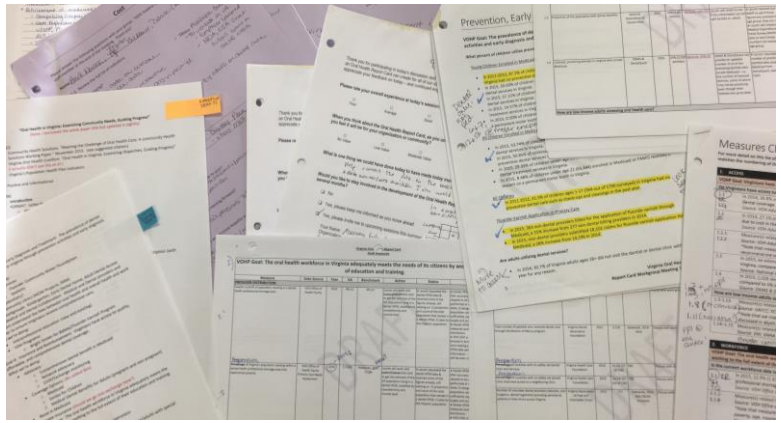
Providers

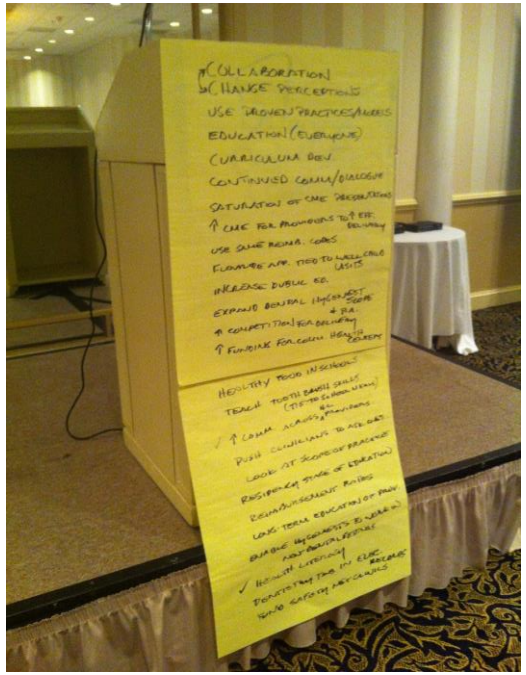
Child and Adult Advocates

Educators

Philanthropy

Grassroots Partners





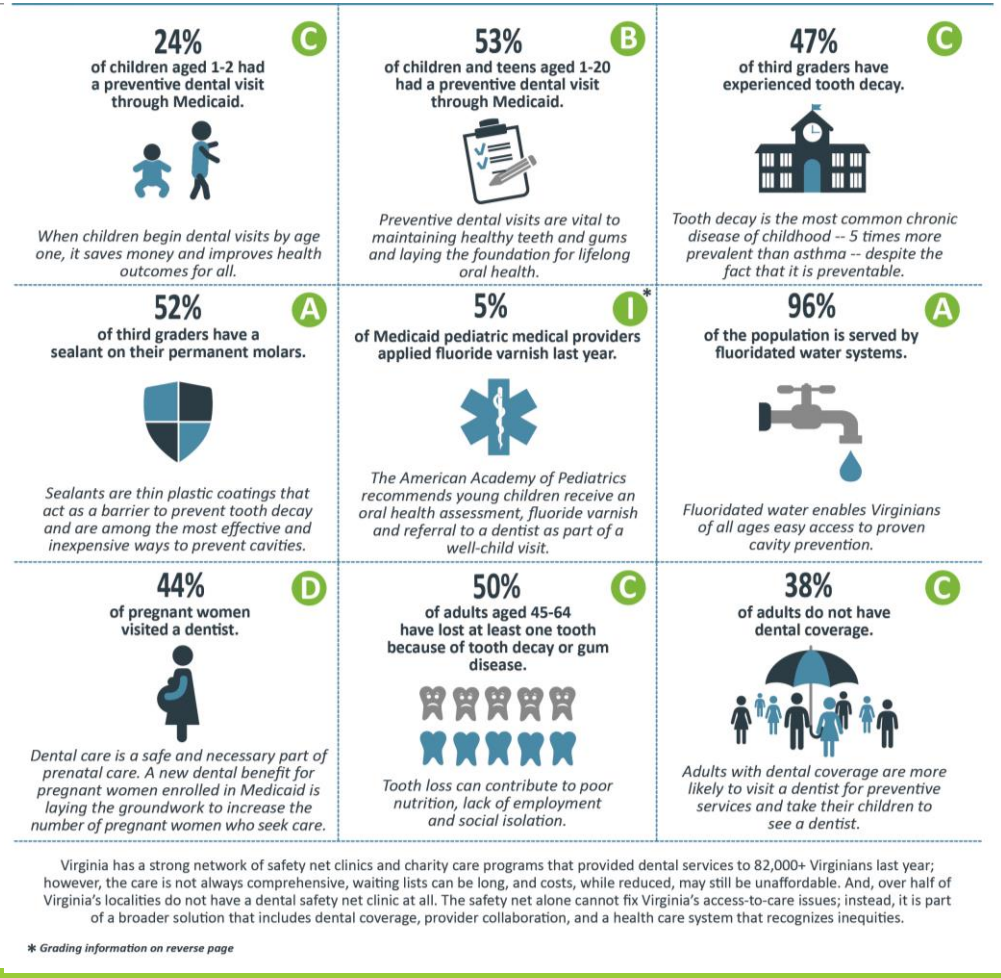
How

- Shared Vision
- Identify Existing Measures
- Health Equity Framework
- Consensus
- Tie to Regional Efforts

Measurement Categories

- Prevention
- Collaboration
- Health Status
- Coverage

Safety Net
Workforce
Disparities



Grading Scale

How does Virginia Compare to the Nation?

Grade	Points	Criteria
A	4	≥20% better than national
B	3	10 to 20% better than national
C	2	0 to 10% change from national
D	1	10 to 20% worse than national
F	0	≥20% worse than national
I	--	Incomplete; not graded, will monitor progress going forward

Indicator	VA %	US %	Grade
Children aged 1-2 who had a preventive dental visit through Medicaid	23.7	22.2	C
Children aged 1-20 who had a preventive dental visit through Medicaid	53.2	45.4	B
Third graders who have experienced tooth decay	47.4	49.0	C
Third graders who have dental sealants on permanent molars	52.0	37.6	A
Medicaid pediatric medical providers applying fluoride varnish	4.5	--	I
Pregnant women who visited a dentist during pregnancy	43.6	49.0	D
Adults aged 45-64 who have lost at least one tooth because of tooth decay or gum disease	49.6	54.4	C
Population served by fluoridated water systems	96.3	79.6	A
Adults aged 18 and older who do not have dental coverage	37.7	38.9	C

C+

Common Threads

Similar disparities across measures

Virginia ranks just above national average with C+

Collaboration needed to improve

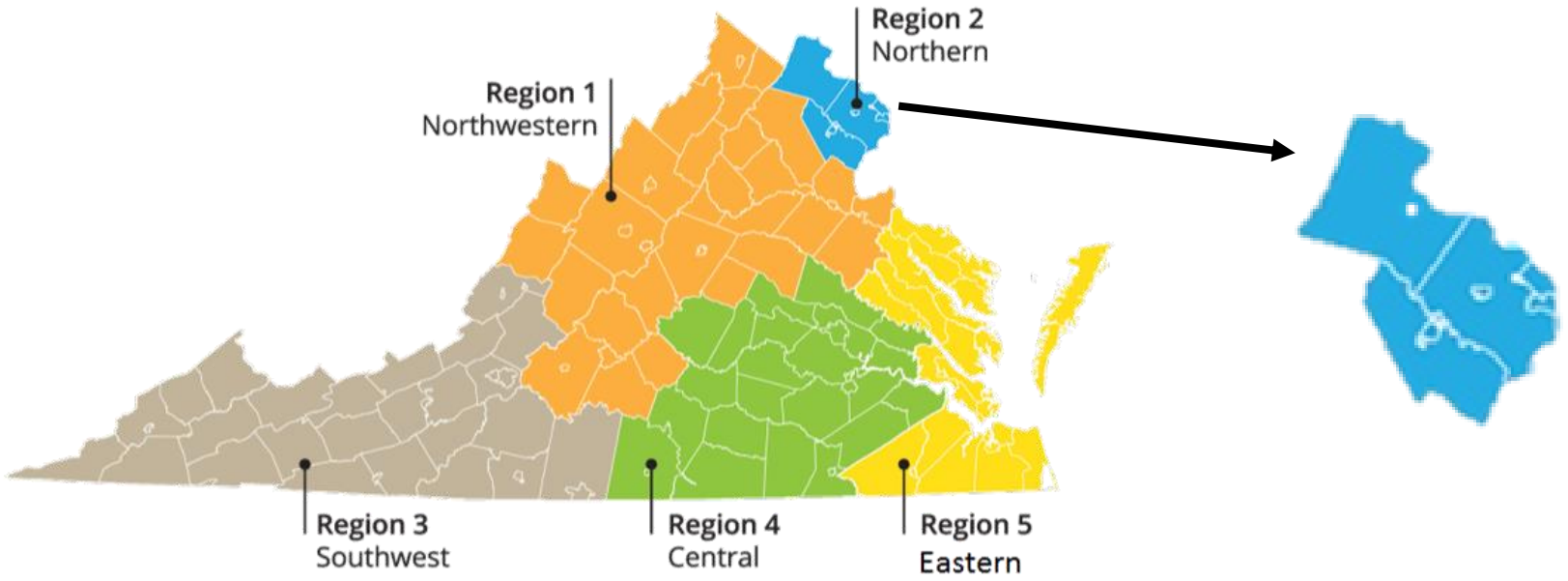
Oral health is health. Good oral health is important for a healthy body; poor oral health is linked to diabetes, heart disease, readiness to learn and work, and even preterm birth. Unfortunately, Virginia only earns a C+ when compared to the nation's performance on nine key oral health indicators.

C+

The good news? We can do better.

Dental disease is preventable. Virginia has the necessary partnerships and commitment - with renewed focus, investment and innovation, we will achieve the best oral health in the nation.

What Now?



Region 2: Northern

Alexandria City
Arlington County
Fairfax City
Fairfax County
Falls Church City
Loudoun County
Manassas City
Manassas Park City
Prince William City
Prince William County

Preventive Services | Children in Medicaid

24%

of children aged 1-2 had a preventive dental visit through Medicaid.

C

When children begin dental visits by age one, it saves money and improves health outcomes for all.

53%

of children and teens aged 1-20 had a preventive dental visit through Medicaid.

B

Preventive dental visits are vital to maintaining healthy teeth and gums and laying the foundation for lifelong oral health.

Children's Decay | Third Graders

47%

of third graders have experienced tooth decay.

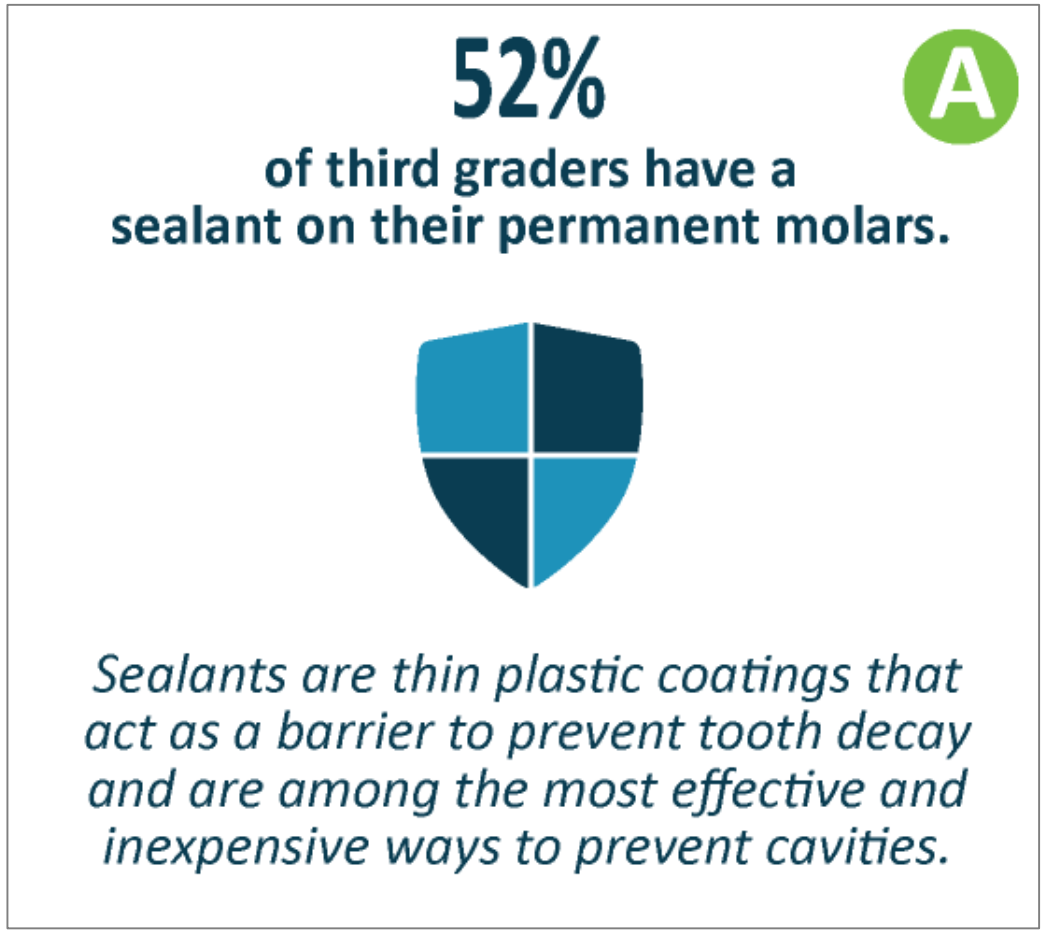
Tooth decay is the most common chronic disease of childhood -- 5 times more prevalent than asthma -- despite the fact that it is preventable.

Disparities

African American students

Students on free/reduced lunch

Sealants | Third Graders



Disparities

African American and Hispanic third graders

Third graders on free/reduced lunch

Collaboration | Fluoride Varnish

5%*

of Medicaid pediatric medical providers applied fluoride varnish last year.

The American Academy of Pediatrics recommends young children receive an oral health assessment, fluoride varnish and referral to a dentist as part of a well-child visit.

In 2016, only 386 Medicaid pediatricians and pediatric nurse practitioners billed for fluoride varnish out of 8,556.

Fluoridated Water | Public Systems

96%

of the population is served by fluoridated water systems.

A

Fluoridated water enables Virginians of all ages easy access to proven cavity prevention.

- Several Localities faced anti-fluoridation advocacy
- Neighboring states have fought major fluoridation battles

Pregnant Women | All Insurance Types

Disparities appear to exist but measurement is challenging

Tooth Loss Due to Decay | Adults

50%

of adults aged 45-64 have lost at least one tooth because of tooth decay or gum disease.

Tooth loss can contribute to poor nutrition, lack of employment and social isolation.

Disparities

African American adults

Adults making less than $25k/year

Adults with less than a high school education

Dental Coverage | Adults

38%

of adults do not have dental coverage.

Adults with dental coverage are more likely to visit a dentist for preventive services and take their children to see a dentist.

Disparities

Hispanic adults

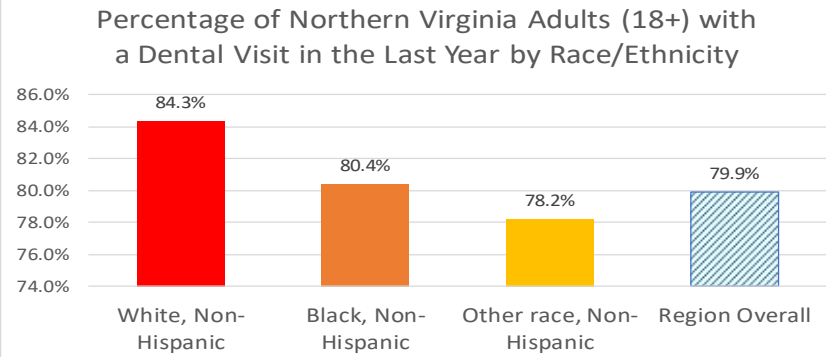
Adults making less than $25k/year

Adults with less than a high school education

Adult Oral Health Data

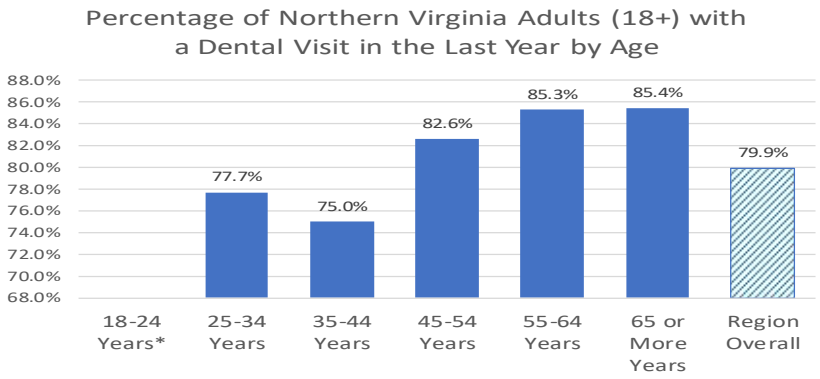
Selected Indicators for the Northern Virginia Region
2010-2016

1



Source: CDC, Behavioral Risk Factor Surveillance System, 2015
Some groups not presented due to statistically unreliable data.
Differences between groups not tested for statistical significance.

2



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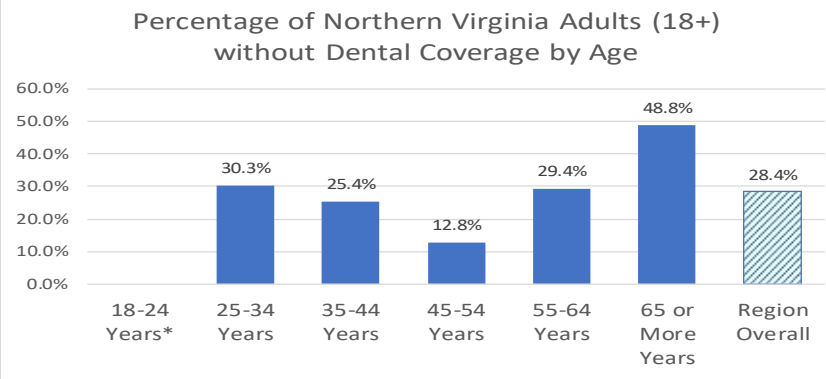

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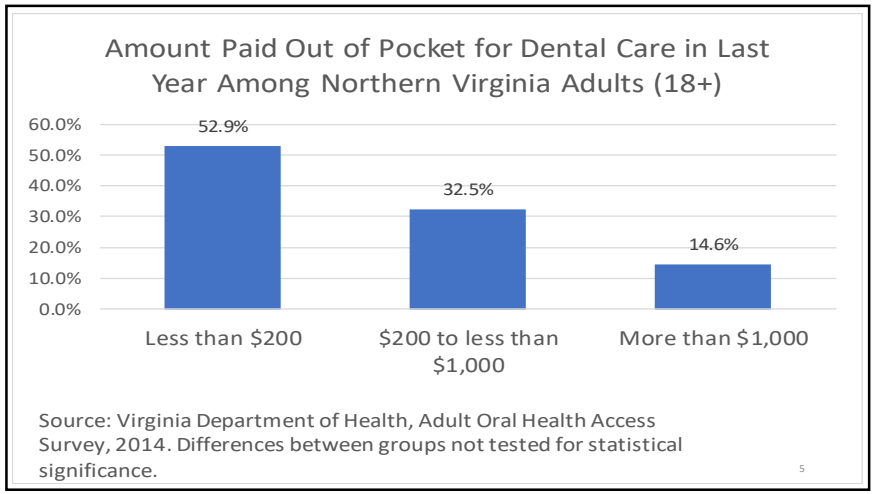
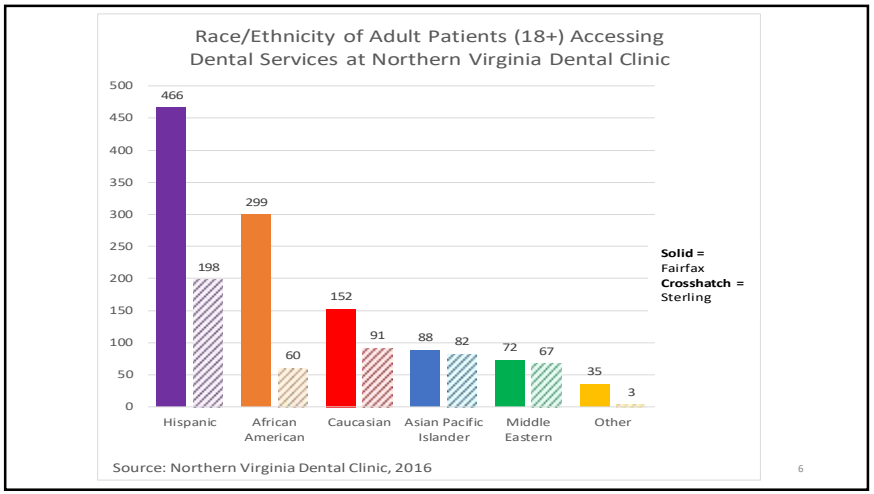
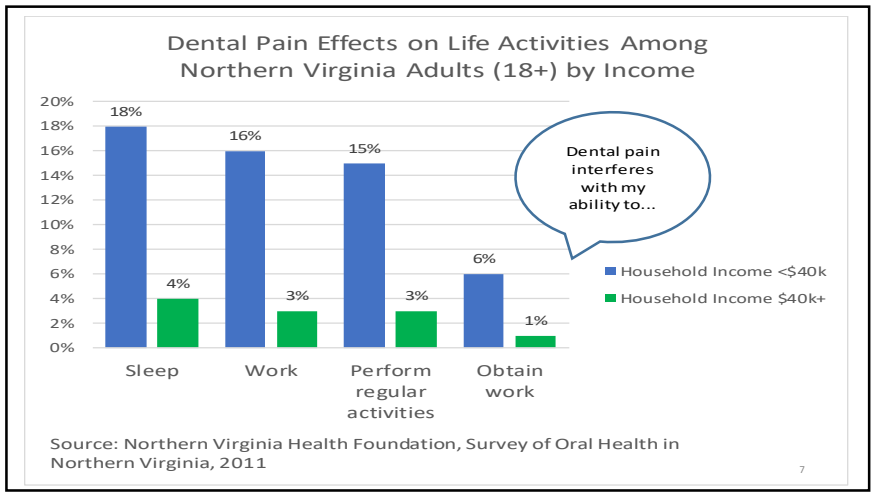
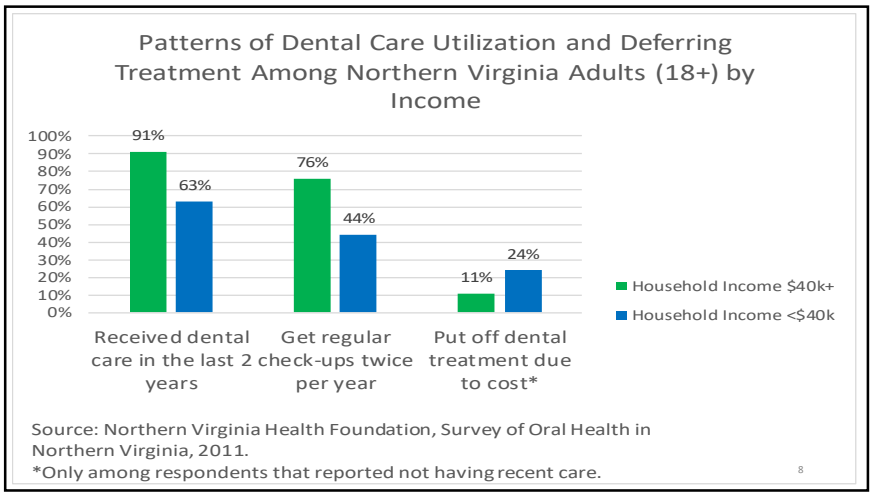
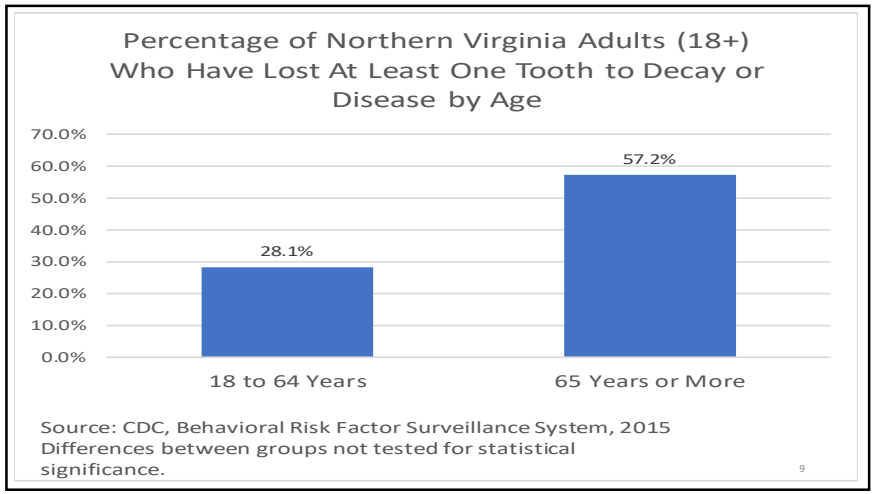
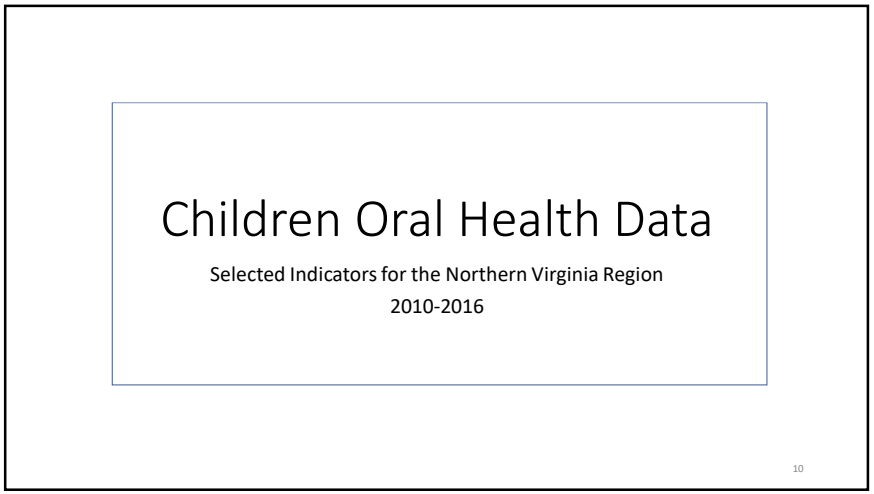

Amount Paid Out of Pocket for Dental Care in Last Year Among Northern Virginia Adults (18+)
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
52.9%
32.5%
14.6%
Less than $200
$200 to less than $1,000
More than $1,000
Source: Virginia Department of Health, Adult Oral Health Access Survey, 2014. Differences between groups not tested for statistical significance.
5

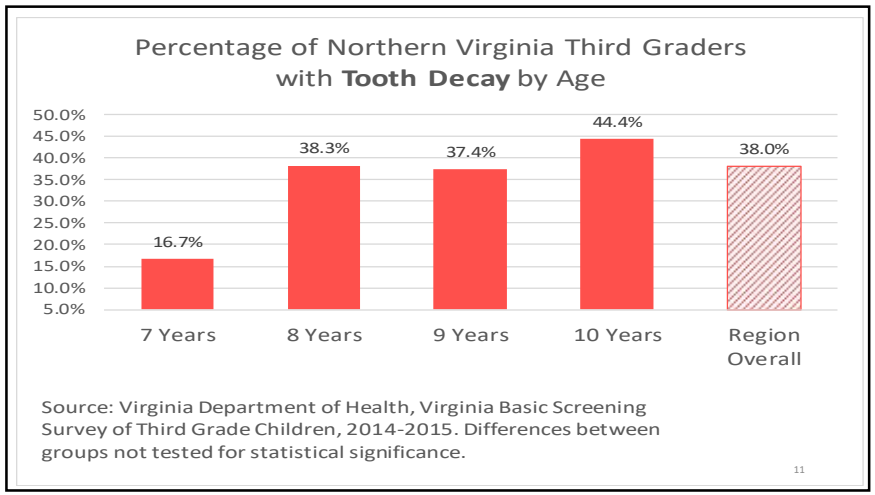

Race/Ethnicity of Adult Patients (18+) Accessing Dental Services at Northern Virginia Dental Clinic
500
450
400
350
300
250
200
150
100
50
0
466
198
299
60
152
91
88
82
72
67
35
3
Hispanic
African American
Caucasian
Asian Pacific Islander
Middle Eastern
Other
Solid = Fairfax
Crosshatch = Sterling
Source: Northern Virginia Dental Clinic, 2016
6

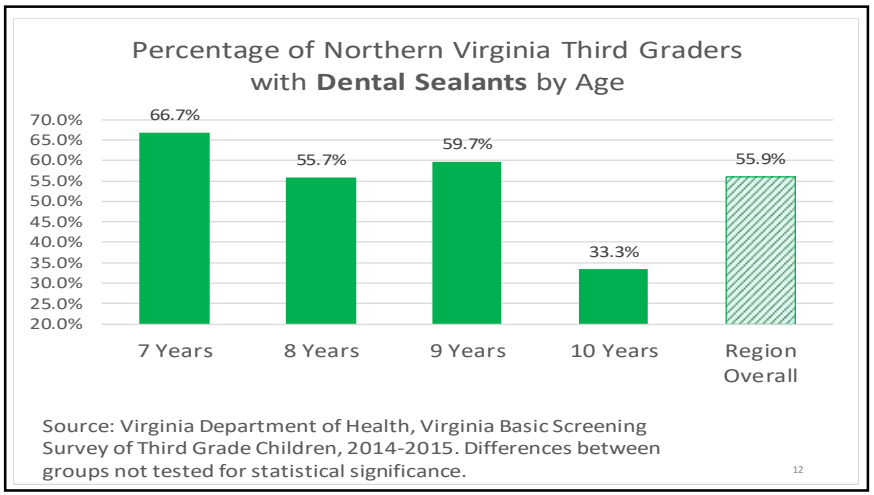

Dental Pain Effects on Life Activities Among Northern Virginia Adults (18+) by Income
20%
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
18%
4%
16%
3%
15%
3%
6%
1%
Sleep
Work
Perform regular activities
Obtain work
Dental pain interferes with my ability to...
Household Income <$40k
Household Income $40k+
Source: Northern Virginia Health Foundation, Survey of Oral Health in Northern Virginia, 2011
7

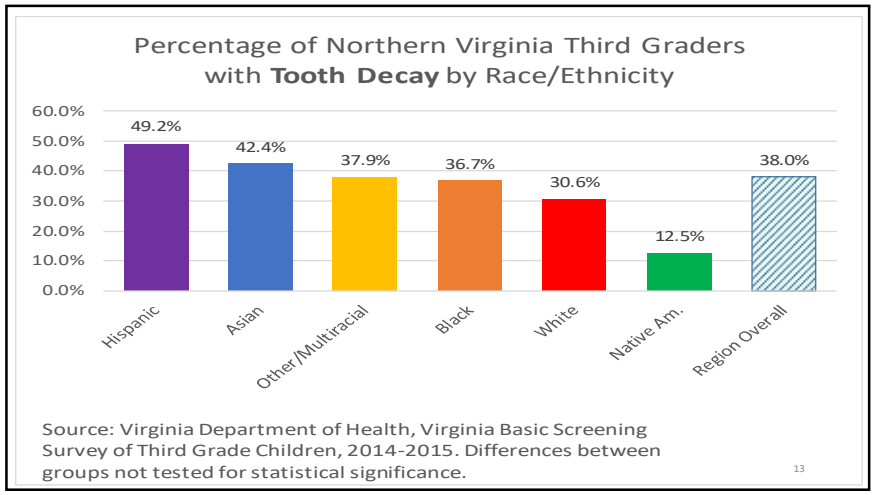

Patterns of Dental Care Utilization and Deferring Treatment Among Northern Virginia Adults (18+) by Income
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
91%
63%
76%
44%
11%
24%
Received dental care in the last 2 years
Get regular check-ups twice per year
Put off dental treatment due to cost*
Household Income $40k+
Household Income <$40k
Source: Northern Virginia Health Foundation, Survey of Oral Health in Northern Virginia, 2011.
*Only among respondents that reported not having recent care.
8

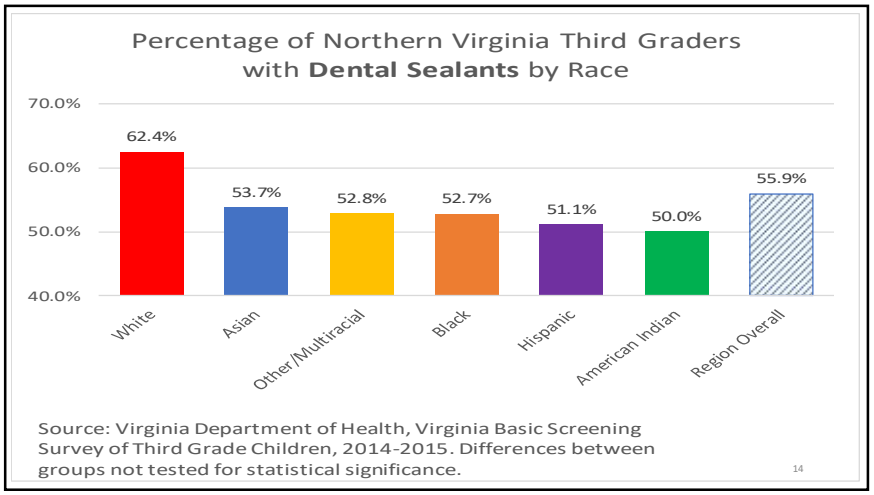

Percentage of Northern Virginia Adults (18+) Who Have Lost At Least One Tooth to Decay or Disease by Age
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
28.1%
57.2%
18 to 64 Years
65 Years or More
Source: CDC, Behavioral Risk Factor Surveillance System, 2015
Differences between groups not tested for statistical significance.
9

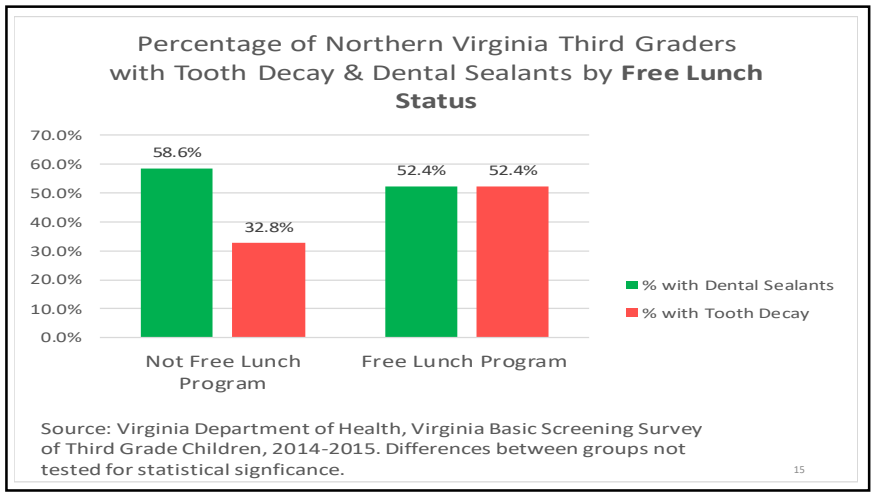

Children Oral Health Data
Selected Indicators for the Northern Virginia Region
2010-2016
10

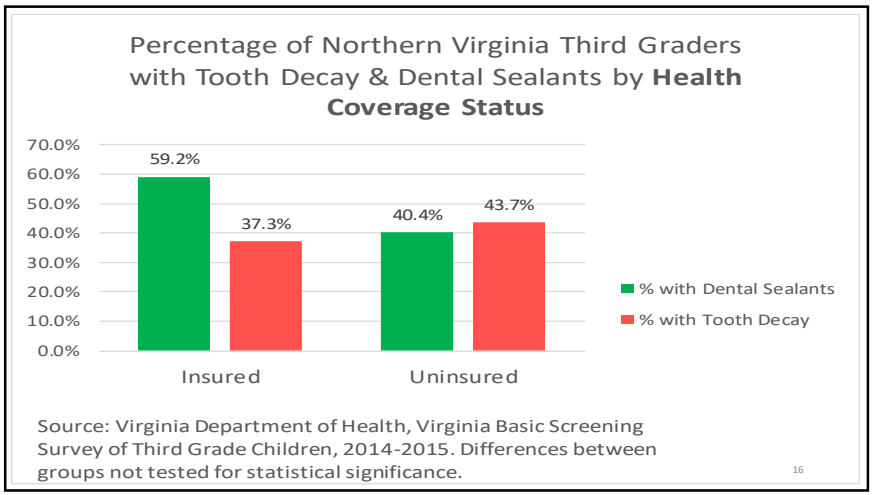

Percentage of Northern Virginia Third Graders with Tooth Decay by Age
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
16.7%
38.3%
37.4%
44.4%
38.0%
7 Years
8 Years
9 Years
10 Years
Region Overall
Source: Virginia Department of Health, Virginia Basic Screening Survey of Third Grade Children, 2014-2015. Differences between groups not tested for statistical significance.
11

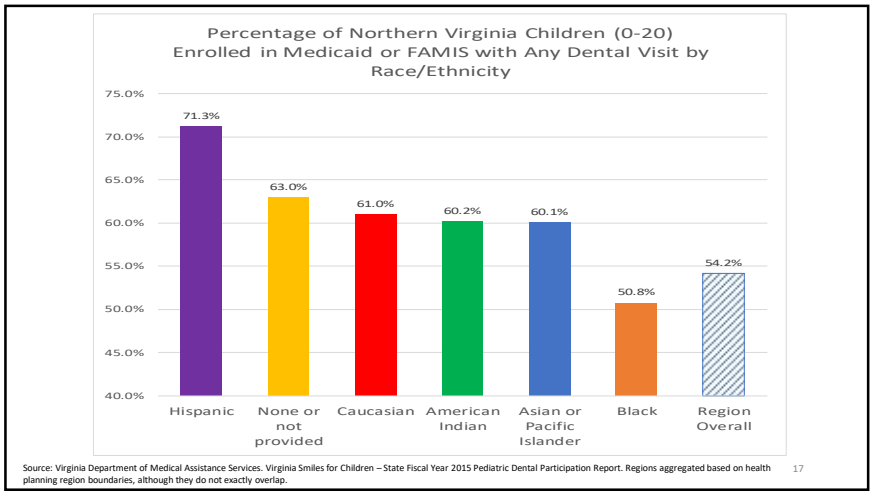

Percentage of Northern Virginia Third Graders with Dental Sealants by Age
70.0%
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
66.7%
55.7%
59.7%
33.3%
55.9%
7 Years
8 Years
9 Years
10 Years
Region Overall
Source: Virginia Department of Health, Virginia Basic Screening Survey of Third Grade Children, 2014-2015. Differences between groups not tested for statistical significance.
12

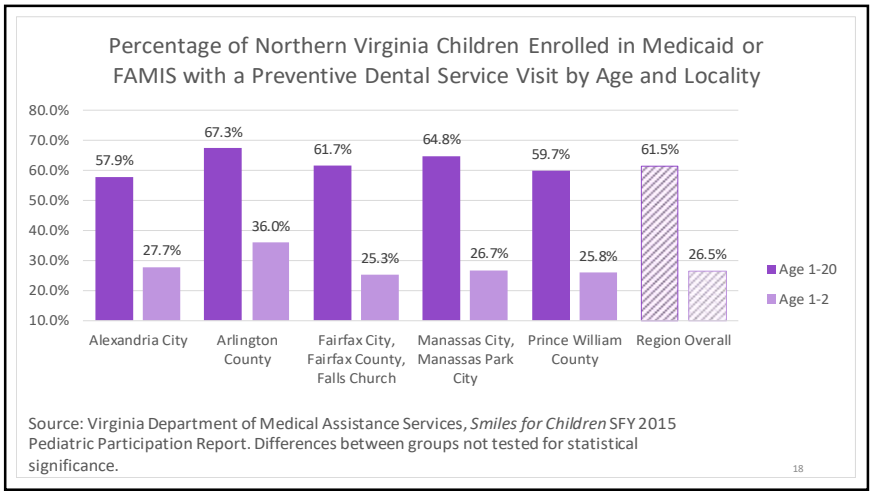

Percentage of Northern Virginia Third Graders with Tooth Decay by Race/Ethnicity
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
49.2%
42.4%
37.9%
36.7%
30.6%
12.5%
38.0%
Hispanic
Asian
Other/Multiracial
Black
White
Native Am.
Region Overall
Source: Virginia Department of Health, Virginia Basic Screening Survey of Third Grade Children, 2014-2015. Differences between groups not tested for statistical significance.
13

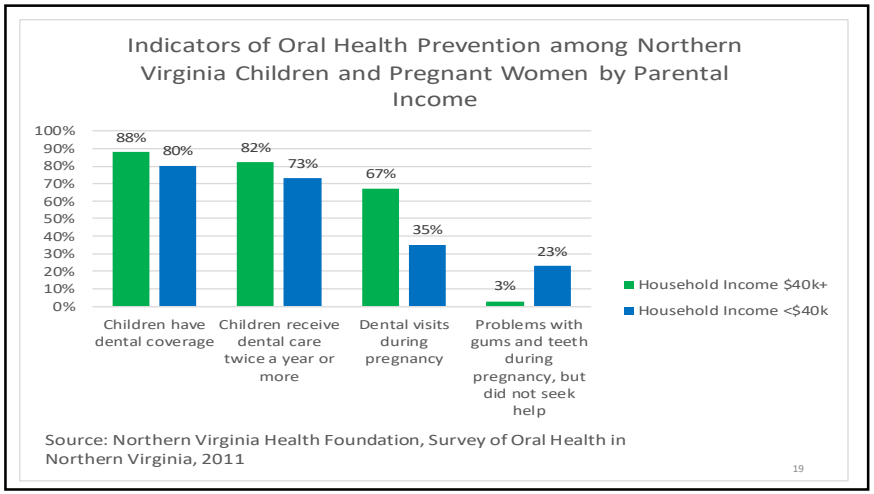

Percentage of Northern Virginia Third Graders with Dental Sealants by Race
70.0%
60.0%
50.0%
40.0%
62.4%
53.7%
52.8%
52.7%
51.1%
50.0%
55.9%
White
Asian
Other/Multiracial
Black
Hispanic
American Indian
Region Overall
Source: Virginia Department of Health, Virginia Basic Screening Survey of Third Grade Children, 2014-2015. Differences between groups not tested for statistical significance.
14


Percentage of Northern Virginia Third Graders with Tooth Decay & Dental Sealants by Free Lunch Status
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
58.6%
32.8%
52.4%
52.4%
Not Free Lunch Program
Free Lunch Program
% with Dental Sealants
% with Tooth Decay
Source: Virginia Department of Health, Virginia Basic Screening Survey of Third Grade Children, 2014-2015. Differences between groups not tested for statistical signficance.
15


Percentage of Northern Virginia Third Graders with Tooth Decay & Dental Sealants by Health Coverage Status
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
59.2%
37.3%
40.4%
43.7%
Insured
Uninsured
% with Dental Sealants
% with Tooth Decay
Source: Virginia Department of Health, Virginia Basic Screening Survey of Third Grade Children, 2014-2015. Differences between groups not tested for statistical significance.
16


Percentage of Northern Virginia Children (0-20) Enrolled in Medicaid or FAMIS with Any Dental Visit by Race/Ethnicity
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
71.3%
63.0%
61.0%
60.2%
60.1%
50.8%
54.2%
Hispanic
None or not provided
Caucasian
American Indian
Asian or Pacific Islander
Black
Region Overall
Source: Virginia Department of Medical Assistance Services. Virginia Smiles for Children – State Fiscal Year 2015 Pediatric Dental Participation Report. Regions aggregated based on health planning region boundaries, although they do not exactly overlap.
17


Percentage of Northern Virginia Children Enrolled in Medicaid or FAMIS with a Preventive Dental Service Visit by Age and Locality
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
57.9%
27.7%
67.3%
36.0%
61.7%
25.3%
64.8%
26.7%
59.7%
25.8%
61.5%
26.5%
Alexandria City
Arlington County
Fairfax City, Fairfax County, Falls Church
Manassas City, Manassas Park City
Prince William County
Region Overall
Age 1-20
Age 1-2
Source: Virginia Department of Medical Assistance Services, Smiles for Children SFY 2015 Pediatric Participation Report. Differences between groups not tested for statistical significance.
18


Indicators of Oral Health Prevention among Northern Virginia Children and Pregnant Women by Parental Income
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
88%
80%
82%
73%
67%
35%
3%
23%
Children have dental coverage
Children receive dental care twice a year or more
Dental visits during pregnancy
Problems with gums and teeth during pregnancy, but did not seek help
Household Income $40k+
Household Income <$40k
Source: Northern Virginia Health Foundation, Survey of Oral Health in Northern Virginia, 2011
19

Compiled Responses from Data Walk

Northern Virginia Oral Health Forum

Thursday, January 26, 2017 | Tysons, VA

Where specific comments were made about a particular chart, the page and chart number from the accompanying handout are given.

Adult Oral Health Indicators	Children Oral Health Indicators
1. What most surprises you or challenges you about this data? Why?	
General: • Lack of information regarding American Indian and Asian/Pacific Islander populations • Degree of oral health problems despite having some of the richest communities in the state • Adults in NOVA are accessing the dentist • Chronic conditions may be impacting oral health • % that responded, know the criteria for the sample • Even when dental insurance is available, they don't take advantage of it (employable years) • Lack of details about the groups • No info on statistical validity – size of sample not known Specific data points: • Dental visit in the last year by race – surprised that Hispanic data is not included [pg 1, slide 2] • % of NOVA – where is the Hispanic – is that a huge gap? Very low (unreliable) #s of adults surveyed per CDC [pg 1, slide 2] • Broader representation of communities: How do you reach them? Social media? [pg 1, slide 2] • Is data inconclusive? Hispanic represented – how does region compare to state and country? [pg 1, slide 2] • Dental visit by age: 18-24 – need good cross-section of entire population in surveys. Too general data – subdata – age, disabilities, access to care. [pg 1, slide 3] • % with dental visit, 65+ was 85.4% [pg 1, slide 3]	General • Data not statistically significant? • Population size is not clear. • What is the sample made of? • Put state and national comparison on posters • Even when children have insurance (Medicaid) they do not access care • How limited data was for kids • Not surprised Medicaid utilization the same across region if looked at all kids suspect see differences • Surprised sealant rate is low across all races – opportunity: some dentists and pediatricians are fully bought in • Sample size and statistical validity not known • Not seeing a larger connection between lack of sealants and prevalence of tooth decay • Low sealants even in affluent area • High % of tooth decay Specific data points: • What happens between 7 to 8 years old to explain big jump in tooth decay rates? [pg 3, slide 11] • Tooth decay by age – anesthes. in office don't accept Medicaid – need collaboration between services – not true representation huge jump in decay between 7-8 years [pg 3, slide 11] • 7 yrs: 17%, 8 yrs: 38.3%, 10 yrs: 44.4% - what happens between 7 & 8 years? [pg 3, slide 11]

- % without dental coverage 18-24 – how to reach? Underrepresented – ½ >65 y/o without coverage but 85% seen by dentist within last year – emergent? [pg 1, slides 3 & 4]
- As adults age, more likely to go to the dentist, also 50% 65+ don't have coverage [pg 1, slides 3-4]
- 45-54 year-olds have lower percentage of dental coverage; not clear insured vs. uninsured [pg 1, slide 4]
- 48% without dental coverage 65+ [pg 1, slide 4]
- Data on decrease in coverage at 45-54 y/o [pg 1, slide 4]
- Unemployment impacted dental coverage by age (2013) [pg 1, slide 4]
- Percentage of 65+being highest for dental visit in last year [pg 1, slide 4]
- Out of pocket costs don't seem so bad [pg 2, slide 5]
- Patient info for NVDC should include demographics for Fairfax and Sterling [pg 2, slide 6]
- Huge disparity related to income and pain [pg 2, slide 7]
- Major impact of pain on activities of daily living (ADLs) for low income [pg 2, slide 7]
- Huge effect of low income on dental pain [pg 2, slide 7]
- Patterns of care/utilization by income – there isn't too much surprising about this [pg 2, slide 8]
- Percentage who put off dental treatment due to cost is lower than we thought it would be [pg 2, slide 8]
- 24% with incomes <$40k put off dental care vs. 11% with incomes >$40k [pg 2, slide 7]
- Dental visit – higher than thought, but disparities by race [pg 1, slide 2]
- ¼ adults missing teeth [pg 3, slide 9]
- 60% 65+ no surprise [pg 3, slide 9]

- Dental sealants by age [pg 3, slide 12]
- For 3rd grader data – Not enough information regarding private vs. Medicaid insurance. Assumptions made. [pg 3, slides 11-12; pg 4, slides 13-16]
- Reportable measures for primary care providers and oral health (tooth decay and sealant) [pg 3, slides 11-12; pg 4, slides 13-16]
- % decay and tooth: data doesn't indicate when sealants applied? [pg 3, slides 11-12; pg 4, slides 13-16]
- Little disparity in sealants, big in decay – not much correlation between sealants and decay (except for insurance status) [pg 3, slides 11-12; pg 4, slide 16]
- Dental sealants – data doesn't seem to correlate with previous slide – who is applying sealants? Dentist vs. peds [pg 3, slide 12; pg 4, slides 13-16]
- % decay by race/ethnicity: Decay vs. sealants seem to correlate. [pg 4, slides 13-14]
- Native Americans 3rd grade tooth decay is the lowest? [pg 4, slide 13]
- Assumed % of children with decay would be higher than 38% [pg 4, slide 13]
- 50% of 3rd graders don't have sealants [pg 4, slide 14]
- Sealants – white kids 62% - everyone else about 53% [pg 4, slide 14]
- Similar % outcome for sealant rate across income levels [pg 4, slide 15]
- % with health insurance: very broad definition of health insurance – reporting by parents or students [pg 4, slide 16]
- That the tooth decay rates on uninsured side aren't higher [pg 4, slide 16]
- 40% of 1-20 aren't accessing dental services even though enrolled in Medicaid/FAMIS [pg 5, slide 17]
- 60+% Medicaid kids go to dentist – pretty consistent but 71% Hispanic [pg 5, slide 17]

	• It seems that a lot of parents are behind with dental visits for 1-2 age group [pg 5, slide 18] • % with insurance Medicaid/FAMIS [pg 5, slide 18] • Disparity between >$40k and <$40k children not as big as expected [pg 5, slide 19] • Pregnant women <$40k not accessing care (are they in care or not?) [pg 5, slide 19] • Prenatal care really driven by income [pg 5, slide 19] • % of children who receive 2+ dental visits per year (82% with $40k+ income) [pg 5, slide 19]
2. What information is missing? Why is this missing information important?	
<u>General</u>: • Missing correlation between data posters. Leaves a lot of room for deductions. • Access in terms of providers – how many dentists accept Medicaid • Data broken up by gender • Dental care utilization (are these adults covered?) • How data captured in surveillance system • Regional ethnic demographic baseline – how defined? • Race not provided, skewed data • Reasons – don't value dental/oral health? Why not accessing dental care? • What types of services were provided? • More granular data needed (income, # of people in household, race) • Income level of each group, racial composition, geographic info – disparity between age groups (working vs. elderly) important for identifying disparities. Info by county would be more helpful. <u>Specific data points</u>: • Hispanic data missing on race/ethnicity [pg 1, slide 2] • No Hispanic data [pg 1, slide 2] • 1st dental visit in the last year – 80% (are they are covered or not?) [pg 1, slides 2-3]	<u>General</u>: • Specifying time school year vs. calendar year • Private vs. Medicaid vs. uninsured • Were specific populations targeted? • Sample size • Data broken out by gender and sub-region • Parental consent rate? • Dental coverage of pregnant women • The data at face value paints a picture but unless you dive deeper it is not as meaningful • We'd have a better understanding if we knew more about the types and quality of treatment (e.g., when did someone go to the dentist and why?) – we know this is virtually impossible data-wise • Racial inequity • The big thing missing is why • % by race/ethnicity – is it just based on a representation of our community's #s or is it other communities aren't steered to care? Or communities don't value? • Overlay or combine ethnicity, income, etc. • How is data captured in surveillance system? • Absolute #s vs. percentage – are there enough providers? • What is the range of these numbers compared to previous years? Is there a trend we should be paying attention to? Is there a target

• Did those who had a dental visit go for follow-up treatment? [pg 1, slides 2-3] • What was dental visit for? [pg 1, slides 3-4] • No data for 18-24? [pg 1, slides 3-4] • How is dental coverage defined? [pg 1, slide 4] • It is not clear whether out of pocket dental care are for uninsured or insured [pg 2, slide 5] • Out of pocket costs disaggregated [pg 2, slide 5] • Amount paid out of pocket – needs specification of data – looks preventive care only if <$200 – extraction at 14% [pg 2, slide 5] • Are payments made deductibles for insurance or just out of pocket for services? [pg 2, slide 5] • Out of pocket in last year – insurance status not included [pg 2, slide 5] • Dental pain effect: no surprise – people bearing disproportionate amount of problems [pg 2, slide 7] • How pain data and income compare to other regions [pg 2, slide 7] • Patterns of utilization and deferring treatment really interesting. It would be great to know the sample size (meta data) and have more recent. [pg 2, slide 8] • Dental care utilization and deferring treatment – household income <$40k only 25% defer treatment? [pg 2, slide 8] • Deferring treatment: surprise that >$40k deferring treatment not higher. Question vague – what is treatment? Stop-gap vs. true treatment, bandaid vs. cure. [pg 2, slide 8] • The range is too wide for 18-64: meaningful to know who by 18 lost tooth [pg 3, slide 9] • Ages 65+ expect to be higher % [pg 3, slide 9]	goal we are aiming for? Has there been any influence on these numbers from ACA? • Large % of race data not provided can skew the data • 14-18 data-specific/college, young adult data <u>Specific data points</u>: • 3rd graders with sealants by age – what happened between 9 years and 10 years? [pg 3, slide 12] • Is the dental sealants by 3rd grade data cohort data? Hard to understand this chart – not very useful. [pg 3, slides 11-12; pg 4, slides 13-14] • Is race/ethnicity data for kids with tooth decay controlled for education, income, other data? [pg 4, slides 13-14] • Of uninsured third graders are they new-comers or are they eligible for insurance and don't value oral health? [pg 4, slide 16] • Loudoun County left off chart for FAMIS/Medicaid [pg 5, slide 18] • The data was too aggregated – age 1-20 should have been broken down (p 5, slide 17) • What is the age of the children? [pg 5, slide 19] • Did the increase in coverage for pregnant women improve visits (and then outcomes?) [pg 5, slide 20]
3. Does this data help you to understand oral health inequities in Northern Virginia? Why or why not?	
<u>General</u>: • Yes, paints a better picture of who lives in the region • The data mainly showcased race, income, health insurance coverage • The barriers to care weren't highlighted: transportation, time, employment, language, education • Yes, but still gaps in data	<u>General</u>: • No, need sample size • Overall data is too broad • Not providing details • Yes, paints a better picture of who lives in the region

• Maybe the working poor barriers are a place/target for intervention • Not very helpful by race, depending on what your goal is with this slide. Is it because of a targeted intervention where communication is key? Then knowing race vs. 1st language could be helpful. Otherwise, whether or not you see a dentist in the last year seems to be moderated more by SES and not race. • Disparity in access • Cultural perspectives re: prevention • Income snapshots were helpful – yes • Why do parents sacrifice for children but don't see need for themselves? • No, more info is needed to understand the data • Yes, but would be helpful to have more of a breakdown in income <u>Specific data points</u>: • Uninsured folks with lower SES have less access to treatment for pain [pg 2, slide 7] • Dental pain is pretty subjective. Those in low SES status may live with more pain for other reasons in life and not report as high interference with life activity. [pg 2, slide 7] • % Adult lost tooth to decay – high % of 18-64 [pg 3, slide 9] • Big age difference in number of elderly who lost teeth [pg 3, slide 9] • Lost a tooth to decay by age – shows prevalence of periodontal disease [pg 3, slide 9] • Losing teeth >65 years – wear and tear, pre-fluoridation [pg 3, slide 9]	• The data mainly showcased race, income, health insurance coverage • The barriers to care weren't highlighted: transportation, time, employment, language, education • Yes, but would be helpful to know in conjunction with other socioeconomic factors • It appears that even among the insured, there is work to do. • There appears to be no start difference between localities in NOVA. Would be great to see this against other regions in the state. • Does WIC refer to dentist? • Questions: data – seemed vague • Little disparity between ethnicities except whites • Other factors that impact decay = cultural • Native American vs. American Indian • No, the data was insufficient • Somewhat – we felt that more info was needed (mostly specificity and re: sample size and geographic focus) • Yes, helps show where the greatest need is – pregnant women do not seek care <u>Specific data points</u>: • Surprised that children having dental coverage is roughly the same regardless of household income – is this a reflection of Medicaid? [pg 5, slide 19]
4. What questions do you have about this data?	
<u>General</u>: • Why were different years of data collected? • Inconsistencies in data across the board • Need criteria details • Subjective interpretations • Is there out of pocket paid data for pediatrics? I.e., are people more willing to pay for kids? • What kind of care – preventive? Urgent? Emergent?	<u>General</u>: • How the not provided ethnicity affects the data • Statistical significance? • At what age are sealants applied? • Information on migrant population (especially Hispanics) • Language barriers • Transportation • How does VDH get data? (population they're pulling from)

• How do we compare to the national average? • Missing school, ER, and cost data • How data captured in surveillance system • Regional ethnic demographic baseline – how defined? <u>Specific data points</u>: • Are visits prevention or treatment for having had dental visit? [pg 1, slides 2-3] • Coverage by age: what % of lower ages forego dental insurance vs. getting above? [pg 1, slide 3] • Is it only <$200 because that's all the work they required or is it because that's all they were willing to afford despite the need for more extensive work? [pg 2, slide 5] • Out of pocket costs: by household [pg 2, slide 5] • NVDC access – does this data represent that these populations have the greatest need or is it that other communities don't know to access or how to access? [pg 2, slide 6] • Dental pain: household size, access to insurance [pg 2, slide 7] • Can dental pain effects be broken down into smaller groups according to income? i.e. $20k vs $40k [pg 2, slides 7-8; pg 5, slide 19]	• Do parents not know? How does this data compare to parental rates? • More with pediatricians – can apply varnish • Is the data statistically significant? • Can it be broken down further by geographic area? <u>Specific data points</u>: • Does the causal relationship of the sealants really lower tooth decay rates? [pg 3, slides 11-12; pg 4, slides 13-16] • Where is the sealant intervention going already? Is higher SES population getting sealant earlier in identification of tooth decay? [pg 3, slides 11-12; pg 4, slides 13-16] • How much of the sealants are placed on child/baby teeth vs. 2nd/adult teeth? [pg 3, slides 11-12; pg 4, slides 13-16] • No specifications of who is getting care? Need subset (population?) E.g., children with decay are not the same as those with sealants. Shows importance of sealants. [pg 3, slides 11-12; pg 4, slides 13-16] • Why the age difference? Are they primary or adult or insurance status? [pg 3, slide 11] • Sealants – 3rd graders by age? [pg 3, slide 12] • 3rd graders with dental sealants (ages 7-10 seems wide) – does this explain large variance? [pg 3, slide 12] • Really need a sample size for age-related data to determine if differences are significant/meaningful [pg 3, slide 12]

SUMMARY OF REGIONALIZED ORAL HEALTH DATA FROM STATE-LEVEL SOURCES

	Data Source	Population	Granularity	Indicator(s)	Other Variables[1]	Most Recent Data Year
Virginia Oral Health Report Card 2016	Virginia Department of Health (VDH)					
	Basic Screening Survey (BSS) of Third Grade Children	All third graders	• State • Health Planning Region[2]	• Treated and untreated tooth decay (separate and combined) • Sealant placement • Unmet dental care need	• Race/ethnicity • Eligibility for free and reduced lunch • Insurance status (medical)	2014-2015
	Behavioral Risk Factor Surveillance System (BRFSS)	All adults 18+	• State • Health Planning Region • Downloadable maps for Alexandria from CDC's 500 cities project	• Permanent teeth extracted due to decay or disease (1 to 5 teeth, 6+, all, or none) • Past year dental visit • Dental coverage status	• Race/ethnicity • Income category • Health conditions (diabetes, cardiac disease) • Age group	2014 (2013 for dental coverage)
	Pregnancy Risk Assessment Monitoring System (PRAMS)	Postpartum women	• State • Health Planning Region	• Dental visit during pregnancy • Dental problem during pregnancy • Dental visit for a problem during pregnancy	• Race/ethnicity • Income category • Maternal education • Age group • Insurance type (medical)	2010-2011 (2012-2013 data being aggregated)
	Water Fluoridation Reporting & Monitoring System (WRFS)	All Virginians	• State • City/county	• Percent of population served by fluoridated public water systems	Not applicable	2016

[1] Custom reports may be available by request to the agency.

[2] There are five health planning regions: Region 1 – Northwestern; Region 2 – Northern; Region 3 – Southwestern; Region 4 – Central; Region 5 – Eastern. A list of the counties and cities comprising each region is attached at the end of this document.

	Virginia Department of Medical Assistance Services (DMAS)					
	Early & Periodic Screening, Diagnostic, & Treatment (EPSDT) service utilization data	All children enrolled in Medicaid and/or FAMIS, up to age 21	• State • Health planning region[3] • City/county	• Total receiving any dental services • Total receiving preventive dental services • Total receiving treatment dental services • # Medicaid dentists	• Race/ethnicity • Age group • Locality • Medicaid enrollment • FAMIS enrollment	2014-2015
Other available state-level data that can be regionally aggregated	Virginia Department of Health (VDH)					
	Adult Oral Health Access Survey	All adults 18+	• State • Health Planning Region	• Dental coverage status (among adults with medical insurance) • Immediate need for treatment • Past year dental visit • Time since last dental visit • Reasons for delaying treatment • Need for tooth extraction • Self-report oral health status • Inability to work/sleep due to dental pain • Service location of last reported dental visit • Past year out-of-pocket cost of dental care	• Race/ethnicity • Income category • Sex • Age group	2014

[3] VaOHC aggregated based on the VDH's health planning region boundaries, although the overlap with VDH's boundaries is not exactly the same.

Other available state-level data that can be regionally aggregated	Dental Health Professional Shortage Areas (DHPSAs)	All Virginians	• State • Health Planning Region • City/county	• Percentage of population residing in a DHPSA • Individual city/county DHPSA designations available on HRSA's website	Not applicable	Varies
	Virginia Association of Free & Charitable Clinics (VAFCC)					
	Virginia free clinic annual reports	Low-income, uninsured adults 18+	• State • Individual clinics offering any dental services	• Total annual dental visits • Total annual patients receiving dental services • Total annual staff and volunteers providing dental care • Total annual $ value of dental services provided	Not applicable	2015
	Virginia Health Care Foundation (VHCF)					
	Safety net clinics (free clinics and FQHCs)	• Low-income, uninsured adults 18+ • Adults & children eligible for Medicaid/FAMIS	• State • Individual clinics offering any dental services	• Total localities with a safety net clinic offering full-time or part-time dental services	Not applicable	2016

Additional Virginia data sources:

- **VDH**
  - Oral Health (some of these data may not be aggregated by region or county/city)
    - Basic Screening Survey of Head Start programs – pilot phase; includes open-mouth survey data on dental health indicators in children ages 0-5 in Head Start programs.
    - Elder Basic Screening Survey – statewide survey conducted in 2015-2016 in congregate meal sites and in nursing homes/assisted living facilities; includes clinical and survey components. Can produce some summary data, but not representative at the population level. Includes data on caries experience, need for urgent care among some elder populations.
    - Virginia Cancer Registry – oral cancer incidence, mortality and 5-year survival data for all Virginians.

        - Virginia Sealant Efficiency Assessment for Locals and States (SEALS) Database – treated and untreated decay, sealant placement and retention on molar surfaces, receipt of fluoride varnish among 3rd grade children served by sealant program localities.
        - Bright Smiles for Babies (BSB) Fluoride Varnish Program survey – services rendered, # screened, oral health education provided (all districts); treated and untreated decay, immediate need for treatment, parental oral health knowledge (some districts). Population is babies (0-3) receiving services through WIC and local health department clinics.
        - Local health department dental activity reports - # and type of services provided by VDH dental staff in local health departments.
        - Virginia Congenital Anomalies Reporting & Education System – prevalence of cleft lip and palate defects
    - Health equity
        - Health Opportunity Index (HOI) - a group of indicators that provide broad insight into the overall opportunity Virginians have to live long and healthy lives based on the Social Determinants of Health. It is made up of over 30 variables, combined into 13 indicators, grouped into four profiles, which are aggregated into a single Health Opportunity Index. The HOI is reported at both the census tract and county/independent city level.
- **Head Start**
    - Data on the health of children in Head Start for the state may be available by request from that agency. Aggregate reporting includes some indicators of dental health within this population. Going forward VDH has tentative plans to conduct further surveys of children in this population, but none are in progress at this time.
- **Community Health Center Program Data – Health Resources & Services Administration (HRSA)**
    - Federally Qualified Health Center (FQHC) data reported to HRSA, available on HRSA's website
- **Virginia Department of Health Professions (DHP)**
    - Dental Manpower Surveys – gives account of number of active, licensed dental health professionals operating at state and local level, as well as their demographics.
- **Local hospital emergency department dental utilization data**
    - In most studies of ED use for dental-related conditions, three ICD-9 codes comprise ~75% of all emergency department diagnoses related to oral health (matching ICD-10 codes in parentheses):
        - 525.9 – Dental disorder NOS (K08.9)
        - 522.5 – Abscess w/out sinus (K04.7)
        - 521.00 – Dental caries NOS (K02.9)
- **Local/regional community health needs assessment survey data**
    - Arlington County in the process of doing a community health assessment
    - Community Healthcare Coalition of Greater Prince William
    - Inova Alexandria Hospital
    - Inova Fairfax Medical Campus
    - Inova Fair Oaks Hospital
    - Inova Loudoun Hospital
    - Inova Mount Vernon Hospital

- Loudoun County Community Health Status Assessment
- Northern Virginia Health Foundation reports
  - 2011 Survey of Oral Health in Northern Virginia – point-in-time phone (cell and landline) survey of 1,300 adults (aged 18+) in 2010. Respondents were grouped based on income level. Survey findings found significant disparities in access to dental care, need, impact on daily life, use of emergency care, and satisfaction with care between income groups. The most significant factors affecting the ability of residents to improve oral health were: income level, access to dental coverage, and use of preventive dental care.
  - How Healthy is Northern Virginia? (2013)
- Prince William Coalition for Human Services Community Health Needs Assessment (Prince William County, Manassas City, and Manassas Park)
- Prince William Medical Center (Prince William County, Manassas City, Manassas Park, and Fauquier County)
- Sentara Northern Virginia Medical Center (Prince William County, Lorton County, and Stafford County)
- Virginia Hospital Center (Arlington County, Fairfax County, Alexandria City)

Community health improvement plans:

- Alexandria Community Health Improvement Plan
- Fairfax Community Health Improvement Plan
- Loudoun Community Health Improvement Plan

National oral health data sources:

- National Survey of Children's Health (NSCH) & National Survey of Children with Special Healthcare Needs (NS-CSHCN)
  - Tracks a number of oral health indicators among children 0-17 and among children with special healthcare needs. New 2016 data should become available in 2017.
- National Oral Health Surveillance System (NOHSS)
  - CDC-maintained system cataloging oral health indicators for adults and children, state-by-state for entire nation. VDH reports data to CDC NOHSS, and many of these indicators can be obtained directly from VDH.

NOVA-SPECIFIC REPORT CARD INDICATORS COMPARED TO STATE & OTHER HEALTH PLANNING REGIONS

Children

- ***38% of Northern Virginia's third grade children had tooth decay*** (treated and/or untreated) in their primary or permanent teeth in 2014-2015, compared to
    - 47% of third grade children overall in Virginia
    - 63% of third grade children in Northwest Virginia
    - 55% of third grade children in Southwest Virginia
    - 50% of third grade children in Central Virginia
    - 43% of third grade children in Eastern Virginia[i]
- ***56% of Northern Virginia's third grade children had dental sealants*** on their permanent molars in 2014-2015, compared to
    - 52% of third grade children overall in Virginia
    - 54% of third grade children in Northwest Virginia
    - 46% of third grade children in Southwest Virginia
    - 54% of third grade children in Central Virginia
    - 48% of third grade children in Eastern Virginia[ii]
- ***61% of children aged 1-20 enrolled in Medicaid/FAMIS in Northern Virginia had a preventive dental service*** in 2014-2015, compared to
    - 53% of children aged 1-20 enrolled in Medicaid/FAMIS overall in Virginia
    - 52% of children aged 1-20 enrolled in Medicaid/FAMIS in Northwest Virginia
    - 50% of children aged 1-20 enrolled in Medicaid/FAMIS in Southwest Virginia
    - 54% of children aged 1-20 enrolled in Medicaid/FAMIS in Central Virginia
    - 48% % of children aged 1-20 enrolled in Medicaid/FAMIS in Eastern Virginia[iii]
- ***27% of children aged 1-2 enrolled in Medicaid/FAMIS in Northern Virginia had a preventive dental service*** in 2014-2015, compared to
    - 24% of children aged 1-2 enrolled in Medicaid/FAMIS overall in Virginia
    - 20% of children aged 1-2 enrolled in Medicaid/FAMIS in Northwest Virginia
    - 16% of children aged 1-2 enrolled in Medicaid/FAMIS in Southwest Virginia
    - 31% of children aged 1-2 enrolled in Medicaid/FAMIS in Central Virginia
    - 24% of children aged 1-2 enrolled in Medicaid/FAMIS in Eastern Virginia[iv]

Adults

- ***36% of adults aged 45-64 in Northern Virginia reported having lost at least one tooth due to tooth decay or gum disease*** in 2015, compared to
    - 50% of adults aged 45-64 overall in Virginia
    - 50% of adults aged 45-64 in Northwest Virginia
    - 61% of adults aged 45-64 in Southwest Virginia
    - 54% of adults aged 45-64 in Central Virginia

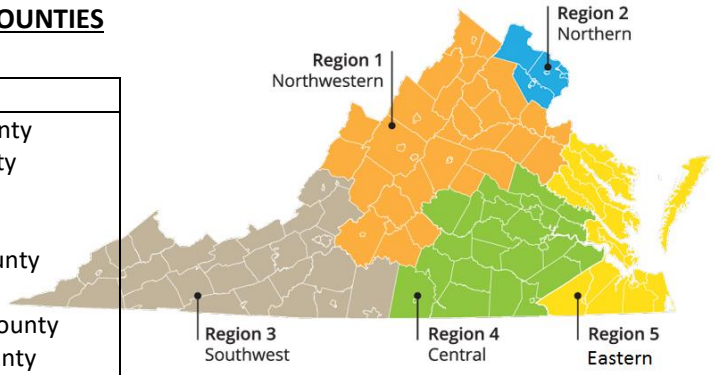
    - 55% of adults aged 45-64 in Eastern Virginia.[v]
- ***28% of adults aged 18+ in Northern Virginia reported not having dental insurance coverage*** in 2013, compared to
    - 38% of adults aged 18+ overall in Virginia
    - 40% of adults aged 18+ in Northwest Virginia
    - 52% of adults aged 18+ in Southwest Virginia
    - 35% of adults aged 18+ in Central Virginia
    - 35% of adults aged 18+ in Eastern Virginia.[vi]

ADDITIONAL STATEWIDE MEASURES OF VIRGINIA'S ORAL HEALTH (REGIONAL %s NOT AVAILABLE)

- ***5% of Medicaid pediatric medical providers applied fluoride varnish*** in 2016.[vii]
- ***96% of Virginia's population is served by fluoridated public water systems*** in 2016, compared to 80% of the U.S. population overall.[viii]

VDH HEALTH PLANNING REGIONS – LIST OF CITIES & COUNTIES

1 – Northwestern	2 – Northern	3 – Southwestern	4 – Central	5 – Eastern
Albemarle County	Alexandria City	Alleghany County	Amelia County	Accomack County
Amherst County	Arlington County	Bland County	Brunswick County	Chesapeake City
Appomattox County	Fairfax City	Botetourt County	Buckingham County	Essex County
Augusta County	Fairfax County	Bristol City	Charles City County	Franklin City
Bath County	Falls Church City	Buchanan County	Charlotte County	Gloucester County
Bedford City	Loudoun County	Carroll County	Chesterfield County	Hampton City
Bedford County	Manassas City	Clifton Forge City	Colonial Heights City	Ilse of Wight County
Buena Vista City	Manassas Park City	Covington City	Cumberland County	James City County
Campbell County	Prince William City	Craig County	Dinwiddie County	King and Queen County
Caroline County	Prince William County	Danville City	Emporia City	King William County
Charlottesville City		Dickenson County	Goochland County	Lancaster County
Clarke County		Floyd County	Greensville County	Matthews County
Culpeper County		Franklin County	Halifax County	Middlesex County
Fauquier County		Galax City	Hanover County	Newport News City
Fluvanna County		Giles County	Henrico County	Norfolk City
Frederick County		Grayson County	Hopewell City	Northampton County
Fredericksburg City		Henry County	Lunenburg County	Northumberland County
Greene County		Lee County	Mecklenburg County	Poquoson City
Harrisonburg City		Martinsville City	New Kent County	Portsmouth City
Highland County		Montgomery County	Nottoway County	Richmond County
King George County		Norton City	Petersburg City	Southampton County
Lexington City		Patrick County	Powhatan County	Suffolk City
Louisa County		Pittsylvania County	Prince Edward County	Virginia Beach City
Lynchburg City		Pulaski County	Prince George County	Westmoreland County
Madison County		Radford City	Richmond City	Williamsburg City
Nelson County		Roanoke City	Surrey County	York County
Orange County		Roanoke County	Sussex County	
Page County		Russell County		
Rappahannock County		Salem City		
Rockbridge County		Scott County		
Rockingham County		Smyth County		
Shenandoah County		Tazewell County		
Spotsylvania County		Washington County		
Stafford County		Wythe County		
Staunton City		Wise County		
Warren County				
Waynesboro City				
Winchester City				



Addendum: Full Web Addresses for Embedded Hyperlinks (In Order of Appearance)

PAGE 1

Downloadable maps for Alexandria: https://www.cdc.gov/500cities/map-books.htm#ui-id-93

PAGE 3

Individual city/county DHPSA designations available on HRSA's website: https://datawarehouse.hrsa.gov/tools/analyzers/geo/ShortageArea.aspx

PAGE 4

Health Opportunity Index (HOI): https://www.vdh.virginia.gov/omhhe/hoi/
Federally Qualified Health Center (FQHC) data reported to HRSA, available on HRSA's website: https://bphc.hrsa.gov/datareporting/index.html
Dental Manpower Surveys: https://www.dhp.virginia.gov/hwdc/default.htm
Arlington County community health assessment: https://health.arlingtonva.us/pha/community-assessment/
Community Healthcare Coalition of Greater Prince William: http://www.vdh.virginia.gov/content/uploads/sites/24/2016/11/Community-Health-Assessment.pdf
Inova Alexandria Hospital: http://www.inova.org/upload/docs/Community/Inova-Alexandria-Hospital-Community-Health-Needs-Assessment.pdf
Inova Fairfax Medical Campus: http://www.inova.org/upload/docs/Community/Inova-Fairfax-Medical-Campus-Community-Health-Needs-Assessment.pdf
Inova Fair Oaks Hospital: http://www.inova.org/upload/docs/Community/Inova-Fair-Oaks-Hospital-Community-Health-Needs-Assessment.pdf
Inova Loudoun Hospital: http://www.inova.org/upload/docs/Community/Inova-Loudoun-Hospital-Community-Health-Needs-Assessment.pdf
Inova Mount Vernon Hospital: http://www.inova.org/upload/docs/Community/Inova-Mount-Vernon-Hospital-Community-Health-Needs-Assessment.pdf

PAGE 5

Loudoun County Community Health Status Assessment: https://www.loudoun.gov/DocumentCenter/View/101387
2011 Survey of Oral Health in Northern Virginia: http://novahealthfdn.org/wp-content/uploads/NVHF-OralHealth-Report-FINAL.pdf
How Healthy is Northern Virginia? (2013): http://novahealthfdn.org/wp-content/uploads/How-Healthy-Is-Northern-Virginia.pdf
Prince William Coalition for Human Services Community Health Needs Assessment: http://www.pwchs.org/Docs/2015%20Community%20Needs%20Assessment.pdf
Prince William Medical Center: https://www.novanthealth.org/Portals/92/novant_health/documents/about_us/community/NHPWMC_CHNA_FINAL.pdf
Sentara Northern Virginia Medical Center: https://www.sentara.com/Assets/Pdf/About-Us/Community-Health-Needs-Assessments/SNVMC-2016-Community-Health-Needs-Assessment-Report.pdf
Virginia Hospital Center: https://sitemanager.acsysinteractive.com/vSiteManager/VirginiaHosp/Public/Upload/SubmittedDocuments/VHC_Community_Health_Needs_Assessment_2014.pdf
Alexandria Community Health Improvement Plan: http://healthieralexandria.org/uploadedFiles/healthieralexandria-wwwroot/FINAL%20CHIP%20Jan%202015(2).pdf

Fairfax Community Health Improvement Plan: http://www.fairfaxcounty.gov/livehealthy/pdfs/community-health-improvement-plan.pdf
Loudoun Community Health Improvement Plan: https://www.loudoun.gov/DocumentCenter/View/49126
National Survey of Children's Health (NSCH) & National Survey of Children with Special Healthcare Needs (NS-CSHCN): http://childhealthdata.org/learn/NSCH
National Oral Health Surveillance System (NOHSS): http://www.cdc.gov/oralhealthdata/

[i] Virginia Department of Health. Virginia Statewide Basic Screening Survey of Third Grade Children, 2014-2015. Estimates with 95% confidence intervals (in order listed): NOVA region: 38.0% (34.4, 41.6); Virginia overall: 47.2% (44.9, 49.6); Northwest region: 62.6% (55.4, 69.7); Southwest region: 54.9% (48.0, 61.7); Central region: 50.1% (42.3, 57.8); Eastern region: 43.4% (40.2, 46.6). Weighted for population estimates.

[ii] Virginia Department of Health. Virginia Statewide Basic Screening Survey of Third Grade Children, 2014-2015. Estimates with 95% confidence intervals (in order listed): NOVA region: 55.9% (51.7, 60.1); Northwest region: 54.4% (47.2, 61.7); Southwest region: 54.9% (38.8, 52.4); Central region: 53.9% (47.8, 59.9); Eastern region: 47.5% (42.8, 52.2). Weighted for population estimates.

[iii] Virginia Department of Medical Assistance Services. Virginia *Smiles for Children* – State Fiscal Year 2015 Pediatric Dental Participation Report. Regions aggregated based on health planning region boundaries, although they do not exactly overlap.

[iv] Virginia Department of Medical Assistance Services. Virginia *Smiles for Children* – State Fiscal Year 2015 Pediatric Dental Participation Report. Regions aggregated based on health planning region boundaries, although they do not exactly overlap.

[v] Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System, 2015. Estimates with 95% confidence intervals (in order listed): NOVA region: 35.7% (30.1, 41.3); Virginia overall: 49.6% (47.3, 51.9); Northwest region: 50.0% (44.9, 55.1); Southwest region: 61.0% (56.8, 65.1); Central region: 53.9% (48.9, 58.9); Eastern region: 55.0% (50.7, 59.4). Weighted for population estimates.

[vi] Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System, 2013. Estimates with 95% confidence intervals (in order listed): NOVA region: 28.4% (24.4, 32.3); Virginia overall: 37.7% (36.2, 39.2); Northwest region: 39.5% (36.1, 43.0); Southwest region: 51.9% (48.9, 54.8); Central region: 34.8% (31.7, 37.9); Eastern region: 34.7% (31.6, 37.8). Weighted for population estimates.

[vii] Virginia Department of Medical Assistance Services, 2016.

[viii] CDC, Water Fluoridation Reporting System, 2016.

Health Equity & Social Determinants of Health Data
Additional Resources

National

- Centers for Disease Control and Prevention (CDC), *Sources for Data on Social Determinants of Health*: https://www.cdc.gov/socialdeterminants/data/index.htm
- CDC, *Data Set Directory of Social Determinants of Health at the Local Level*: https://www.cdc.gov/dhdsp/data_set_directory.htm
- Health Resources & Services Administration (HRSA) Data Warehouse: https://datawarehouse.hrsa.gov/
- National Center for Health Statistics: https://www.cdc.gov/nchs/index.htm
- National Partnership for Action to End Health Disparities, *Federal Interagency Health Equity Team: Compendium of Publicly Available Datasets and Other Data-Related Resources*: https://www.minorityhealth.hhs.gov/NPA/Materials/FIHET_Data_Compendium_508_version_FINAL_11_28_2016.pdf

Virginia

- Atlas of Community Health: http://atlasva.org/action-guides/
- County Health Rankings 2016: http://www.countyhealthrankings.org/app/virginia/2016/overview
- Virginia Department of Health (VDH) Data Portal: http://www.vdh.virginia.gov/data/
- VDH Office of Health Equity – Health Opportunity Index, Health Professional Shortage Areass & Medically Underserved Areas: http://www.vdh.virginia.gov/health-equity/division-of-social-epidemiology/

Virginia Oral Health Coalition
Northern Virginia Oral Health Forum
Thursday, January 26, 2017 | Tysons, Virginia

Attendee List

Virginia Oral Health Coalition Staff:
Sarah Bedard Holland, Executive Director
Samantha Dorr, Communications and Operations Director
Lauren Gray, Program and Engagement Manager

Meeting Facilitator:
Kathy Greenier, Floricane, LLC

Participant Name:	Organization:
Gloria Addo-Ayensu	Fairfax County Health Department
Yahya Alvi	Adams Center
Beatriz Amberman	Virginia Coalition of Latino Organizations
Adriana Araica	Northern Virginia Dental Clinic
Kara Blankner	Cafritz Foundation
Jeanne Booth	Arlington County Department of Human Services
Sally Borkowski	Fairfax County Public Schools - Department of Special Services
Lynn Browder	Virginia Department of Health
Agnes Burkhard	Marymount University
Sultan Chaudhry	Broadway Dental
Maqsood Chaudhry, DDS	Grove Dental Clinic
Richard Chobot	Former Chair of the Fairfax Area Commission on Aging
Camilo Cujar Tovar	AMC Dental Spa
Melissa DeAngelo	Fairfax County Public Schools
Lowell Dempsey	Burness Communications
Caitlin Denney	Prince William Area Free Clinic
Vince Dougherty	Virginia Dental Association
Jesse Ellis	Fairfax County Neighborhood & Community Services
Thomas Fonseca	The Fenwick Foundation
Astrid Gamez	Family Services Network, INC.
David Goodfriend	Loudoun County Health Department
Cathy Griffanti	Northern Virginia Dental Society
Florence Hagan	Fairfax-Falls Church Community Services Board
Bryana Head	Higher Horizons Head Start and Early Head Start

Virginia Oral Health Coalition
Northern Virginia Oral Health Forum
Thursday, January 26, 2017 | Tysons, Virginia

Attendee List

Participant Name:	Organization:
Carol Jameson	HealthWorks for Northern Virginia
Amy Joyner	Fairfax County Office for Children Head Start
Julie Jung	Fairfax County Health Department
Francine Jupiter	Health Care Advisory Board
Susie Lee	Potomac Health Foundation
Allen Lomax	Partnership for a Healthier Alexandria
Andrea Lomrantz	Fairfax County Department of Family Services
Rachel Lynch	Inova
Patricia Mathews	Northern Virginia Health Foundation
Timothy McCue	Potomac Health Foundation
Ondrea McIntyre-Hall	Northern Virginia Family Service
Stacey Minott Hardy	Medical Care for Children Partnership Foundation
Sherry Noud	Fairfax County Public Schools
Barbara Nowak	Alexandria City Public Schools
Gretchen O'Donnell	Head Start
Rahman Parker	Loudoun Free Clinic
Tarang Patel	Virginia Department of Health
Betty Peebles	JCB Foundation
Teresa Polk	Prince William County Public Schools
Nadia Prokofieva	DentaQuest Foundation
Paul Rapavi	Arlington County Public Health Dental Program
Lori Reffett	Northern Virginia Community College, Dental Hygiene Faculty
Carmen Regan	Northern Virginia Dental Clinic
Clara Roberson	Alexandria Department of Community & Human Services/OSC
Tricia Rodgers	Northern Virginia Health Foundation
Mindy Rubin	Kaiser Foundation
Eileen Sarsfield	Marymount University
Raja'A Satouri	Fairfax County Health Department
Kristy Savoy	Office for Children Early Head Start
Scott Schoenborn	Interleukin Genetics
Kasia Shaw	A-SPAN

Virginia Oral Health Coalition
Northern Virginia Oral Health Forum
Thursday, January 26, 2017 | Tysons, Virginia

Attendee List

Participant Name:	Organization:
Irrin Suvanasai	Wesley Housing
Natalie Thornock	Greater Mount Vernon Community Head Start
Tri Tran, DDS	Arlington Free Clinic
Marcia Twomey	Medical Care for Children Partnership Foundation
Montressor Upshaw	Neighborhood Health
Lora Vece	George Mason University & Prosperity Primary Care
Katie Warner	Youth Empowered Solutions (YES!)
Elliott Waters	Self Employed Clergy
Barbara (Babs) Waters	Alexandria Commission on Aging
Thomas Wilson	Northern Virginia Dental Clinic
Jacquie Woodruff	Fairfax Area Agency on Aging
Lesby Zavala	Northern Virginia Family Service
Pouneh Zeraat	Fairfax-Falls Church Community Services Board