

Improving Oral Health in Maine

Key Lessons for Policy Advocates



Partnership for
Children's
Oral Health



This issue brief was produced by the Partnership for Children’s Oral Health (Partnership) and the Children’s Dental Health Project (CDHP). The Partnership is a Maine-based network that catalyzes collaboration and innovation in order to eradicate dental disease among Maine children. CDHP is a policy institute in Washington D.C. that works to eliminate dental disease as a driver of inequities for children and families. Learn more about our organizations by visiting www.mainepecoh.org and www.cdhp.org.

Background

A variety of factors shape whether an advocacy effort is effective. One such factor is the messages used by advocates to drive policy change. In 2017, the Children’s Dental Health Project (CDHP) commissioned two national research projects to learn which messages would be more effective at encouraging policymakers to make oral health a priority. These projects were in-depth interviews and a virtual focus group of policymakers and influencers from diverse states. These two national research projects produced important insights. CDHP learned there are significant knowledge gaps about oral health. Moreover, policymakers seem to be mostly unaware of the human and financial costs that dental disease has on families and taxpayers.

In 2018, CDHP sought to expand its understanding by testing whether its initial findings would be reinforced or challenged by focus groups within particular states. In June 2018, CDHP conducted focus groups in two counties in central Texas. Several months later, in September, CDHP sponsored similar focus groups in two regions of Maine with the financial support of the Dental Trade Alliance Foundation and in-kind support from the Maine-based Partnership for Children’s Oral Health (Partnership). The Maine communities were chosen to reflect the state’s

Defining Terms

Policymakers: People at the local, state and federal levels who develop, adopt or implement the laws, regulations or practices that affect the public’s health and well-being. These individuals include state legislators; Medicaid officials; city council members; county commissioners; members of Congress; and hospital or health systems administrators. Even school boards can be health policymakers because most of them approve budgets that decide what health services will be offered to students and how many schools will be staffed with nurses.

Influencers: Individuals who have greater leverage over policymakers than most Americans. Typically, this leverage comes from their professional or social reputation, and/or the frequency of their interactions with policymakers. Those interactions include learning about and advocating for an issue by sending emails to elected officials, signing petitions, or attending “town hall” meetings or other civic events.

geographic and income diversity. On September 26th, a focus group was convened with residents in Brewer, a city in northern Maine’s Penobscot County (PC). The county’s population is about 150,000, and its poverty rate is above the national average. On the following evening, a focus group of influencers was conducted in Saco, a city in York County (YC)—Maine’s southernmost county. Roughly 200,000 people live in YC, where the poverty rate is below the national average. The racial and ethnic composition of residents in PC and YC are similar. YC’s population is growing, while PC’s is declining.

For each focus group in Texas and Maine, influencers were recruited by using a questionnaire. Confirmed participants reported having engaged in some form of civic or political participation within the past 12 months. Forms of participation included writing or calling an elected official; attending a community meeting to hear about a local issue; posting a social media message about a public or political issue; and being an active member of a Rotary Club, women’s organization or other civic group. Each Maine influencer had interacted in one of these ways with a local, state or national policymaker at least five times during the previous 12 months.

Maine participants were diverse in gender, age, educational achievement and income level. In addition, they were from a variety of personal or professional backgrounds, including a medical technician, retired aircraft mechanic, elementary school teacher, small business owner and homemaker. (A representative of the Partnership attended each focus group as an observer.) The following table offers basic information about both counties and their participants.

Table 1:

Penobscot County (PC)	York County (YC)
Population: 151,957	Population: 204,191
Poverty Rate: 14.8%	Poverty Rate: 8.1%
Participants: 10 (5 men, 5 women)	Participants: 9 (6 women, 3 men)
Participants for both focus groups were recruited through a questionnaire to ensure they were actively engaged in civic and political affairs. Recruitment services were provided by the Portland Research Group, a leading market research firm in Maine.	

Rating Their County

Participants were asked to rate the health and well-being of residents in their respective counties using a 1-10 scale. (Choosing a 10 meant residents’ health was outstanding, while a rating of 1 meant their health was poor.) Neither focus group rated their county highly. The average rating chosen by PC participants was 6.1, while the average for YC was 4.4. These assessments were slightly higher than the scores given by Texas influencers in June 2018.

Overlooked Issues

When asked to name the “overlooked health issues” in their counties, participants of both focus groups shared challenges that overlapped. These included mental health, obesity, diabetes, aging issues, alcoholism, access to primary care, cancer and elder care.

None of the 19 participants volunteered dental health as an overlooked issue. However, when the moderator raised this topic, most participants immediately agreed that dental health in their counties deserved more attention from policymakers. A participant in YC said, “The fact that we initially didn’t mention [dental health] is proof that it’s overlooked.”

Attendees’ concerns ranged from the affordability of dental insurance to the out-of-pocket costs of care. They also voiced frustration about the small portion of dentists who participate in MaineCare, the state’s Medicaid program. One participant complained that her husband’s employer “picked a type of insurance that almost no dentist in the Portland area accepts.”

Knowledge Gaps

Participants were aware about some aspects of oral health, but the dialogue revealed several gaps in their knowledge. Although awareness varied, Table 2 distinguishes what most participants knew from what they did not know.

Table 2:

What Many of Them Knew	What Many of Them Didn't Know*
<ul style="list-style-type: none"> ● Dental care operates in a world separate from medical care, and that can create access problems. ● Dental care is unaffordable for many Maine residents. Even if someone is insured, the costs of premiums and co-pays can strain a household budget. ● Only a limited number of dentists accept my or my child’s dental insurance. 	<ul style="list-style-type: none"> ● Tooth decay is a chronic, bacteria-driven disease process that can be prevented or halted with appropriate interventions. ● Medicaid expansion in Maine would not change MaineCare’s emergency-only dental benefits for adults. ● Dentists aren’t the only people who can do an oral health risk assessment. ● Dentists are not required to accept Medicaid-enrolled patients.
<p><i>*Several WC participants were unaware of what dental sealants were and how they were helpful for children’s oral health.</i></p>	

Although several participants talked about a failure of parents and other individuals to make oral health a priority, many raised structural barriers to care. A PC participant criticized the separate systems of medical and dental care, which complicate access. “It would be nice,” he said, “if dental and medical could be as one.”





Others noted that many low-wage families struggle to find a MaineCare-participating dentist. “To me, it’s not just behavior necessarily, said a YC participant. “It’s the access and the ability to pay.”

Participants agreed that cost is a major barrier to getting regular dental care. “I spent a lot of time calling around to dentists trying to see if any of them had a payment plan to make it more affordable,” said a YC participant. “None of them had a payment plan.” A small business owner shared a story about what one of her employees endured, seeking treatment for a toothache. “The oral surgeon wouldn’t do anything without \$600 upfront, and she had no money,” said the businesswoman. “Her tooth became abscessed and it became a medical emergency so it’s only when it gets really, really bad that [the system] will do something about it.”

Most Persuasive Facts

A sheet with 10 dental health facts was circulated to each focus group (see Addendum A). Participants were asked to read each fact and choose no more than three that would be most likely to persuade Maine policymakers to view oral health as a priority. Table 3 shows the top four facts chosen by the 19 participants. Two of the four most popular facts dealt with the consequences of poor oral health.

Table 3:

Which facts would resonate most with Maine policymakers?	
Maine is one of only 13 states that limit adults’ Medicaid dental coverage to only emergency care. This means low-income adults aren’t covered if they need preventive care like exams and cleanings, or treatments like getting a cavity filled.	 11
Young children with a lot of cavities generally need to be treated under general anesthesia in hospital operating rooms. Data shows this kind of hospital treatment costs between \$5,000 and \$15,000 per child.	 9
Research shows that children with poor oral health are nearly 3 times more likely than their peers to be absent from school. And teens with poor oral health are 4 times more likely to earn below-average grades.	 7
Tooth decay is the most common chronic disease of children and teens — and even more common than asthma.	 7

Number of participants who chose each fact as one of the 4 most convincing facts

PC participants were twice as likely as those in YC to choose the costs of treating childhood decay in hospitals. YC participants were much more likely to choose the fact related to children’s school achievement. After making their choices, participants discussed why their selected facts would be more compelling to policymakers. One focus group attendee said it might “shame” legislators to act if they realized that Maine is one of only 13 states where Medicaid-enrolled adults lack preventive dental

benefits. Several others saw MaineCare’s weak dental benefits as the fact that policymakers need to hear over and over. As a PC participant lamented, “MaineCare—they’ll pull a tooth, but that’s all they will do (for adults).”

The cost of treating children with rampant decay in hospital settings was the second-most chosen fact. A participant at the YC focus group said, “I would think someone at the state level would say: ‘Wow, (addressing) that could save us a lot of money.’”

“I don’t think dental care often is talked about as a chronic disease. I mean, that is a very strong word.”

The fact that linked poor oral health and children’s performance in school was also one of the most chosen facts. YC participants were much more likely to choose this fact than PC attendees.

Tooth decay’s status as the most common chronic disease among kids was chosen by more than one-third of the participants. “I don’t think dental care often is talked about as a chronic disease. I mean, that is a very strong word,” said a woman in the PC focus group. A male participant agreed, adding that identifying tooth decay as a chronic disease is a “pretty powerful” statement. This same fact stood out to a YC woman but for a different reason: “The [fact] about asthma could really get policymakers’ attention because Maine has one of the highest rates of childhood asthma.”

Arguments for Adult Coverage

In these focus groups, we tested messages advocating for improvements to MaineCare’s (Medicaid) adult dental benefits. Participants were reminded that the state does not cover preventive services for adults. We tested two messages with distinct themes (see Addendum B):

- The first message focused on adults’ dental needs through the frame of parenthood. Participants received a graph showing that Medicaid-enrolled children in Connecticut were more likely to obtain dental care in a given year when their parents had also received dental services. (Participants agreed that the same connection probably existed in Maine.) The crux of the first message was that Maine could “improve the health of both parents and their kids” by improving Medicaid dental benefits for adults.

- The second message sidestepped the parenthood issue and focused, instead, on the fact that adults “with unhealthy or missing teeth are at a disadvantage in the job market.” This message explained that unemployed or low-wage adults “cannot afford the cost of private dental insurance,” making Medicaid their only realistic way to access dental care.

Participants were asked to decide which message would be more likely to convince policymakers to act on this issue—or if the messages were equally persuasive. The message focused on employment was chosen by 11 participants. The message frame around parenthood was rated more convincing by five participants. Three attendees felt each message was equally persuasive.

PC participants were equally divided by the three options, but YC attendees overwhelmingly chose Message B. One participant explained why she preferred B: “It talks about jobs. There are people who aren’t in the workforce, and, if they had dental care, would be in the workforce.”

Testing Messages for Adult Dental Coverage	More Convincing
<p>Message A (uses parenthood to promote adult coverage) When parents or caregivers get dental care, their children are more likely to receive dental services. Unfortunately, MaineCare covers a comprehensive set of preventive dental services for children but almost none for their parents. Currently, only emergency dental treatment is covered for adults. Our state’s Medicaid program should cover dental services for adults as soon as possible. By taking this step, we can improve the health of both parents and their kids.</p>	5
<p>Message B (uses employment to promote adult coverage) People with unhealthy or missing teeth are at a disadvantage in the job market. To live and work without toothaches or other dental problems, adults need access to affordable dental care. But adults who are unemployed or in low-wage jobs usually cannot afford the cost of private dental insurance. Medicaid is their only realistic way to access dental care. Yet MaineCare only covers emergency dental treatment for adults. It’s time to change that by giving all Medicaid-enrolled adults access to dental services—not just emergency care. It’s a smart investment for better health.</p>	11
<p>Neither message is more convincing than the other.</p>	5

Several participants offered passionate arguments for why Maine policymakers should expand Medicaid dental benefits. A woman attending the YC focus group shared her story: “If you make it where somebody can go to the dentist if they have a toothache, instead of going the emergency room, they’re going to go to the dentist.”

Pregnancy & Oral Health

Participants received a brief handout that cited the connection between a woman’s oral health during pregnancy and her newborn’s risk for tooth decay. Additionally, the handout referenced studies linking gum disease and pregnancy complications.

Participants in each focus group were asked to rate the handout’s messages on a scale of 1 to 5 (see Addendum C). A 5 rating meant they felt the statement would be highly convincing to policymakers; a 1 meant it would not be at all convincing. The average score from PC participants was 2.1 on the five-point scale. YC participants gave the handout an average score of 3.0.

Although attendees agreed the issue of oral health during pregnancy deserved policymakers’ attention, they were skeptical that the messages shared would spur state leaders to act.

Some focus group members pointed to a lack of awareness about the impact of oral health on pregnancy. “My daughter was just pregnant, and this information was never brought up with her,” said a woman in the PC focus group. “Nobody said anything about these things.”

Another participant felt legislators would react cynically to a call for expanded coverage during pregnancy. “There are some pretty interesting facts here, but we’re talking about lawmakers who are looking at money. Everything’s about money. They’re going to look at this and go: ‘Why didn’t that woman take care of her teeth before?’”

Risk Assessments & Oral Health

Participants were asked to read a handout (see Addendum D) explaining a new approach to keeping children cavity-free. Under this approach, children are given a risk assessment to determine their risk



level for *caries*—the disease that causes tooth decay. Additionally, each child would receive the health care and support they need, based on their individual risk for caries. For example, children at high risk of tooth decay would need more frequent dental services. And their parents would receive more guidance on diet and other habits that could shape their kids’ risk.

As the handout explained, a caries risk assessment can be conducted by dental professionals, a pediatrician or other health providers. These assessments can be performed on children and adults. The handout also informed participants that Northeast Delta Dental reimburses health providers for doing caries risk assessments of Maine adults. However, MaineCare (Medicaid) does not reimburse for risk assessments.

Participants were handed a sheet with three messages (see Addendum E) that could be used to convince state policymakers to embrace the risk assessment approach for MaineCare-enrolled children. They were asked to share their open-ended reactions to each message—what they liked or didn't like. Addendum F provides a summary of their reactions.

Overall, most participants liked this approach driven by risk assessments. Enthusiasm was slightly higher in the YC focus group with one of its participants asking rhetorically: “Isn't prevention always the better tool? How many times are we learning that lesson?” Another YC participant felt this approach “would be so easy to implement.”

However, some participants—mostly in the PC group—wondered if existing barriers to care could hinder this approach. One PC participant asked how this approach would “open up care for anyone if there aren't the resources available” to address the problems found during the risk assessment. Proponents of using risk assessments in this way will need to be prepared to address this and other concerns that policymakers might raise. For example, it is worth conveying that dentists aren't the only health professionals capable of doing a risk assessment; this could reassure policymakers that workforce capacity is not an obstacle to doing risk assessments for all children.







After considering the persuasiveness of different messages, participants were given four options to name this overall approach to care. They overwhelmingly favored the name *individualized care* over the other three options: risk-based care, need-based care, and tailored care. As was true in the Texas focus groups, Maine participants felt the term “risk-based care” sounded too negative. A PC resident said, “The word ‘individualized’ hits on all levels.”

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Comparing Maine with Texas

CDHP conducted focus groups of influencers in both Maine and Texas. The messages tested in each state were very similar, and the minor differences were aimed at accounting for differences in each state’s political and policy landscape.

Participants in each state echoed many of the same observations and concerns about the cost of and access to dental care. In addition, participants in both states felt it would be tough to persuade their legislatures to make oral health a priority issue. However, there were a few distinctions between the states in the views expressed by focus group participants:

Differences between Maine and Texas: Although participants in both states had similar concerns and observations, there were a few distinctions that emerged from the focus groups.	
	<ul style="list-style-type: none"> Maine participants were more supportive of using risk assessments as a tool for aligning oral health care with each child’s needs.*
	<ul style="list-style-type: none"> Although Texas participants felt legislators would want specifics on costs or cost savings, Maine participants placed even more emphasis on this.
	<ul style="list-style-type: none"> Maine participants expressed more concern about adults’ oral health needs than did Texas participants. The top-rated fact in the Maine focus groups (see Table 3) was the inability of Medicaid-enrolled adults to receive preventive dental care.
	<ul style="list-style-type: none"> When given two different messages to make the case for improving Medicaid adult dental coverage, Maine participants strongly preferred the message that stressed the impact that poor oral health has on adults’ job prospects. Texas participants slightly preferred the other message, which linked parents’ access to dental care with their children’s likelihood of getting care.

* The stronger support in Maine could partly or entirely be explained by the fact that this approach was not labeled “risk-based care” when we introduced it in that state’s focus groups. Texas participants uniformly disapproved of a name that included the “risk” word, and—when given the choice—Maine participants overwhelmingly chose a different name for this approach.

Key Lessons

- 1 Focus on the consequences of poor dental health:** When asked to choose the oral health facts that they felt would be most convincing to policymakers, participants often picked ones that revealed the consequences—rather than the prevalence—of poor dental health. Two of the four top-rated facts focused on the educational or economic impact of dental disease. Linking oral health to education and other issues that policymakers already care about could be a recipe for success. Moreover, consequence-focused statistics were the most surprising to participants (as compared to prevalence-focused data), which suggests that facts about the impacts of poor oral health might be more helpful in getting the attention of policymakers than numbers showing how common it is.
- 2 Fill in their knowledge gaps:** Dental issues are not top-of-mind, which is one reason why there are significant gaps in knowledge. These gaps can make it tougher to get the attention of elected officials. For example, most of the Maine participants agreed that the typical policymaker is unaware that tooth decay is caused by a disease. In addition, some focus group participants incorrectly assumed that a Medicaid expansion would somehow address MaineCare’s problem of emergency-only adult dental benefits. Some policymakers might be making the same assumption. Before making any “ask” of policymakers, advocates should provide crucial facts that fill these knowledge gaps.
- 3 Cite job opportunities to urge improvement of MaineCare’s adult dental benefits:** Most participants felt that policymakers would be more receptive to improving adult dental benefits if they heard a message framed in the language of job opportunities. In doing so, advocates can cite more than anecdotal evidence. In fact, in a 2015 *American Dental Association survey*, 37 percent of Maine low-income residents reported that the appearance of their mouth and teeth affects their ability to interview for a job.
- 4 Talk about the system:** National research has shown that when asked about dental health issues, most Americans talk about it as an individual responsibility. Policymakers are likely to have the same tendency, which can pose an obstacle to policy change. Advocates’ messages should remind policymakers that people are trying to navigate a broken system. Moreover, it’s worth pointing to various factors outside an individual’s control that affect their oral health—from water fluoridation to public transportation that makes it easier for people to reach dental services. Advocates seeking medical-dental integration can cite how the existing system separates dental and medical care—a separation that frustrated many focus group participants.
- 5 Communicate without the jargon:** Influencers—the people who attended these focus groups—are more engaged and involved in the public dialogue around health issues. Yet even they may not understand many terms that health advocates use regularly. For example, one participant read a handout and then asked: “I wasn’t really sure what ‘health outcomes’ means? It sounds vague.” This is a reminder that advocates who seek to improve dental health should opt for language that is widely understood, avoiding policy jargon and technical terms.

6 Seize opportunities in a new policy climate: Some of the focus group participants saw the then-current legislative leadership as resistant to changes that could improve oral health in Maine. However, the November election brought significant change to Augusta, giving Democrats the governor’s office and control of both chambers of the Maine Legislature. Clearly, this changes the opportunities that advocates have for policy change. Some of these newly elected officials may have priorities that align with the course that advocates wish to plot.



Addendum A:

Facts & Statistics about Oral Health

- 1 Tooth decay is the most common chronic disease of children and teens—and even more common than asthma.

- 2 Young children with a lot of cavities generally need to be treated under general anesthesia in hospital operating rooms. Data shows this kind of hospital treatment costs between \$5,000 and \$15,000 per child.

- 3 About 4 in 10 Maine children have cavities by 3rd grade.

- 4 In a 2015 survey, 37% of low-income adults in Maine said the condition of their teeth and mouth affects their ability to interview for a job.

- 5 Research shows that children with poor oral health are nearly 3 times more likely than their peers to be absent from school. And teens with poor oral health are 4 times more likely to earn below-average grades.

- 6 Only 42% of children enrolled in MaineCare had a dental visit in the most recent year that was studied.

- 7 During a two-year period, more than 9,400 soldiers had dental emergencies that delayed or disrupted their deployment to Afghanistan. The Defense Department identified tooth decay as “a significant reason” why some military personnel are non-deployable.

- 8 Health economists found that adults with better oral health earn 2% more than their peers—and the wage “bump” is even higher for women.

- 9 Maine is one of only 13 states that limit adults’ Medicaid dental coverage to only emergency care. This means low-income adults aren’t covered if they need preventive care like exams and cleanings, or treatments like getting a cavity filled.

- 10 Children with cavities in their baby teeth are 3 times more likely to develop cavities in their permanent (adult) teeth.

Addendum B:

Dental Coverage for Adults

Background

If the Medicaid expansion that voters approved happens in Maine, it will increase the number of adults who qualify for Medicaid medical benefits. But the expansion does not provide basic dental benefits for adults, because those benefits are not part of MaineCare’s existing covered services.

Message A

When parents or caregivers get dental care, their children are more likely to receive dental services. Unfortunately, MaineCare covers a comprehensive set of preventive dental services for children but almost none for their parents. Currently, only emergency dental treatment is covered for adults. Our state’s Medicaid program should cover dental services for adults as soon as possible. By taking this step, we can improve the health of both parents and their kids.

Message B

People with unhealthy or missing teeth are at a disadvantage in the job market. To live and work without toothaches or other dental problems, adults need access to affordable dental care. But adults who are unemployed or in low-wage jobs usually cannot afford the cost of private dental insurance. Medicaid is their only realistic way to access dental care. Yet MaineCare only covers emergency dental treatment for adults. It’s time to change that by giving all Medicaid-enrolled adults access to dental services—not just emergency care. It’s a smart investment for better health.

Check only one of the following boxes:

- Message A would be a more convincing message for policymakers.
- Message B would be a more convincing message for policymakers.
- Neither message would be more convincing than the other.

Addendum C:

Pregnant Women’s Oral Health

Even if we cannot make all low-income adults eligible for MaineCare, some health advocates feel we should at least expand dental benefits for pregnant women. Several states have done so. Here’s why it makes sense for MaineCare to improve dental coverage for women during pregnancy:

- ▶ Some studies show that pregnant women with gum disease are at a higher risk for having low birth-weight babies or other pregnancy complications.
- ▶ Infants are not born with cavity-causing bacteria in their mouths. Research shows that new mothers with poor oral health can unintentionally pass cavity-causing bacteria to their newborns’ mouths by sharing spoons or using their saliva to “clean” a dropped pacifier. Keeping a woman’s mouth healthy during pregnancy can prevent these problems.

On a scale of 1 to 5, how convincing do you think the above reasons would be for getting policymakers (Maine legislators) to improve dental coverage for women during pregnancy?

Circle one number below:



Addendum D:

Giving Each Child the Dental Care They Need

An oral health risk assessment is a way to determine a child’s or adult’s level of risk for tooth decay. It also helps a dentist decide on an appropriate individualized treatment plan that is appropriate for each child’s needs. This risk assessment can be done by a dentist, a pediatrician, a physician’s assistant or other health professionals who interact with patients.

Here’s how an oral health risk assessment works:

- A health professional asks the child’s parent a series of questions (about the child’s diet, the parent’s dental health history, etc.)
- Based on the answers, the child is classified as having a high, moderate or low risk of getting cavities
- Kids who are at high risk of cavities might be covered for seeing a dentist or hygienist 3 or 4 times a year. During these dental visits, they would receive more preventive services.

Doing this assessment usually takes less than five minutes. An oral health risk assessment is an important way to help keep children cavity-free.

Knowing a child’s risk for tooth decay can ensure that more kids get the individualized care they need to prevent decay—or to halt the early stages of decay so it doesn’t create a cavity.

Here’s the good news. If you are a Maine adult who has dental coverage through Northeast Delta Dental, your risk assessment is covered. In fact, getting a risk assessment can open the door to receiving additional dental services that are appropriate for that level of risk.

Here’s the bad news. Unlike Northeast Delta Dental, MaineCare does not reimburse dental professionals for doing risk assessments for children. For this reason, relatively few kids in Maine are getting risk assessments. Keeping these children cavity-free can prevent pain, put them on a healthy path and hold down MaineCare’s costs.

By moving toward a system of risk-based care for oral health, Maine would be doing something good for children and good for taxpayers.

Addendum E:

Providing Care Based on Children’s Individual Needs

Message 1:

Federal health experts report that tooth decay is the No. 1 chronic disease affecting children and teens. Knowing each child’s risk can help a dentist provide the care that fits their risk level. This can prevent toothaches and other dental problems before they happen. And it could also save our state money because young kids with serious dental problems need to be treated in hospitals—and that is very expensive.

Message 2:

Identifying kids who are at high-risk for cavities as early as possible can improve health and save money. We can match dental services with a child’s risk level so that every kid has the opportunity to avoid cavities and stay healthy. From depression to diabetes, our health care system screens people to be able to give them the care they need—the care that fits their risk factor. We need to apply the same approach to oral health so we can direct care more appropriately to kids and make the best use of providers’ resources and time.

Message 1:

We shouldn’t have a one-size-fits-all approach to children’s dental health. We need to assess each child’s individual risk for tooth decay and provide the services that reflect their risk level. Some children might need to see a dentist more often than other kids. Some kids might need additional fluoride treatments. When we do a risk assessment early, we can enable families to work more closely with health professionals to prevent or halt the progression of tooth decay.

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