



San Francisco Children's Oral Health Strategic Plan 2014-2017



Coordinated by
San Francisco Health Improvement Partnership

November 2014



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Tomás Aragón, MD, DrPH
Health Officer, City and County of San Francisco
Director, Population Health Division
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Working on the SF HIP Children’s Oral Health Strategic Plan has been inspiring and transformational! When we work together on a common agenda, with shared measurements and mutually-reinforcing strategies, we can have collective impact on the oral health of our children, which will have a lasting, lifelong impact on their health and quality of life. Our goals are to reduce disparities in oral health, reduce disparities in access to preventive services, and to implement targeted upstream prevention in the community (medical visits, WIC, Head Start, etc.).

Children’s oral health is a headline indicator in the San Francisco Strategic Plan for Population Health because it contributes to the overall health of San Francisco. The SF HIP Children’s Oral Health Strategic Plan is the roadmap within this overall plan, guiding the work of both our San Francisco Department of Public Health, as well as our community efforts to identify and systematically eliminate the causes of dental disease.

The vision of this plan is aspirational – “All children in San Francisco to be caries-free.” The goal is not just to reduce dental decay. There is a clear focus to also reduce disparities, so that all San Francisco children have access to early and routine oral health preventive services. Dental decay is preventable. Studies show us, however, that the children who are most vulnerable to this epidemic are exactly those who do not receive needed dental services. Oral health has been artificially segregated from overall health, and critical preventive guidance and treatment is often delayed until a child is 3 years old. Without integrating oral health into the overall health system we will be continually playing ‘catch-up’. We will never be able to fill all the decayed teeth in San Francisco. This plan promotes the integration of oral disease prevention into locations where children and new parents are seen by health care providers – the well child visit – and increases early access to dental providers at locations such as WIC sites, preschool centers and elementary schools. By instituting this plan, we can prevent the disease process from becoming established.

Congratulations and thank you to the many community collaborators who have the vision of a caries-free San Francisco, and the commitment to do the work required to develop an organized roadmap to that end.



Kevin Grumbach, MD

Chair, UCSF Department of Family and Community Medicine

Co-Director, UCSF Clinical Translational Science Community Engagement
and Health Policy Program

This Strategic Plan represents a vision which started among a group of oral health advocates responding to a challenge: to identify and address what would make the greatest impact on children’s oral health in San Francisco. In San Francisco nearly 40% of children have experienced caries by the time they reach kindergarten, well above the national Healthy People 2020 target of 30%. Untreated caries is 2-3 times more prevalent in children of color, and this disparity has worsened since 2000. At the initial convening of oral health stakeholders in early 2012 as a San Francisco Health Improvement Partnership (SF HIP) Children’s Oral Health working group, it was made clear that to make the most impact, there needed to be a coordinated, citywide strategic planning effort. We now have a three-year plan – a guide that will move our city closer to achieving our goal: to make San Francisco’s children caries-free. We have the tools and the knowledge; with the coordinated effort and resources described in this Strategic Plan, we also have the means to achieve our goal.

The plan reflects a true collaborative effort successfully engaging over eighty individuals’ input and expertise. The enthusiasm and hard work of so many contributed both to the creation of this plan and to raising the overall awareness and profile of oral health and its importance for our children to thrive and succeed in life. Our focus is on five key areas: Access to care, Integration of oral health into overall Health, Promotion, Evaluation and Coordination. Each has been carefully assessed for feasibility and related best practices, thoughtfully discussed in multiple meetings, and further developed as implementation steps detailed in a separate report.

I’m particularly encouraged to see the key strategy emphasizing integration of oral health into routine primary care services for children. Although barriers persist for young children to reach a dentist’s office, most children have multiple visits to primary care clinics and practices for well-child exams in the first few years of life. Yet too often those of us who are primary care medical providers have not integrated basic oral health preventive measures, such as a careful exam for early caries and application of fluoride varnish, into our routine well child exam practice. The Strategic Plan provides a concrete plan for integrating oral health into routine primary care children’s services.

This is an exciting time and a wonderful opportunity to help shape the future of children’s oral health in San Francisco. The Strategic Plan exhibits how we can better address this great health need in a community-centered, integrated, and coordinated approach. Congratulations and thank you to all those involved in this collaboration including the supporters and funders that made this possible. I’m confident that the same vision and dedication that created this plan will fuel its implementation and bring San Francisco closer to health equity for all of our children.



INTRODUCTION

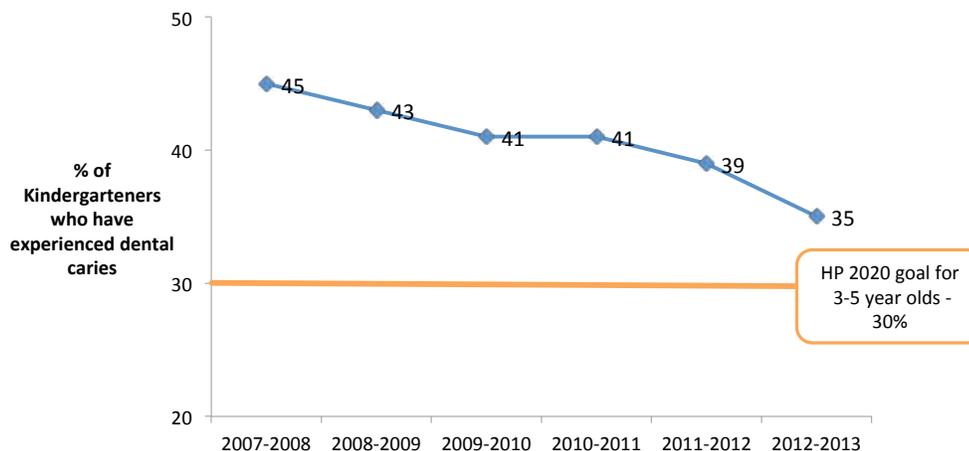
WHY IS ORAL HEALTH IMPORTANT?

Oral health is essential to overall health, well-being, and quality of life. It affects children's nutritional intake, self-esteem, and the ability to concentrate and succeed in school. Dental caries (tooth decay) remains one of the most common chronic diseases in childhood in the U.S. and often persists into adulthood and across the lifespan. In 2012, 35% of San Francisco Unified School District (SFUSD) students experienced dental caries in their primary and permanent teeth by the time they entered kindergarten, resulting in reduced attendance and contributing to poor academic performance. There can also be high costs; dental caries-related emergency room visits can be ten times the cost of providing preventive care.

ORAL HEALTH STATUS OF SAN FRANCISCO

Over the past decade there has been steady improvement in the oral health status of San Francisco children: the prevalence of untreated caries declined from 26% of kindergarteners in 2007 to 17% in 2012. During the same period, caries experience which reflects not only current but past tooth decay has also declined from 45% to 35%. (Figure 1) However, the 2020 Healthy People (HP) objective to reduce the proportion of children aged 3 to 5 years who experience dental caries in their primary teeth to 30% has not been met for San Francisco 4-5 year olds. We can do more to reduce dental decay in our infants, toddlers and preschoolers.

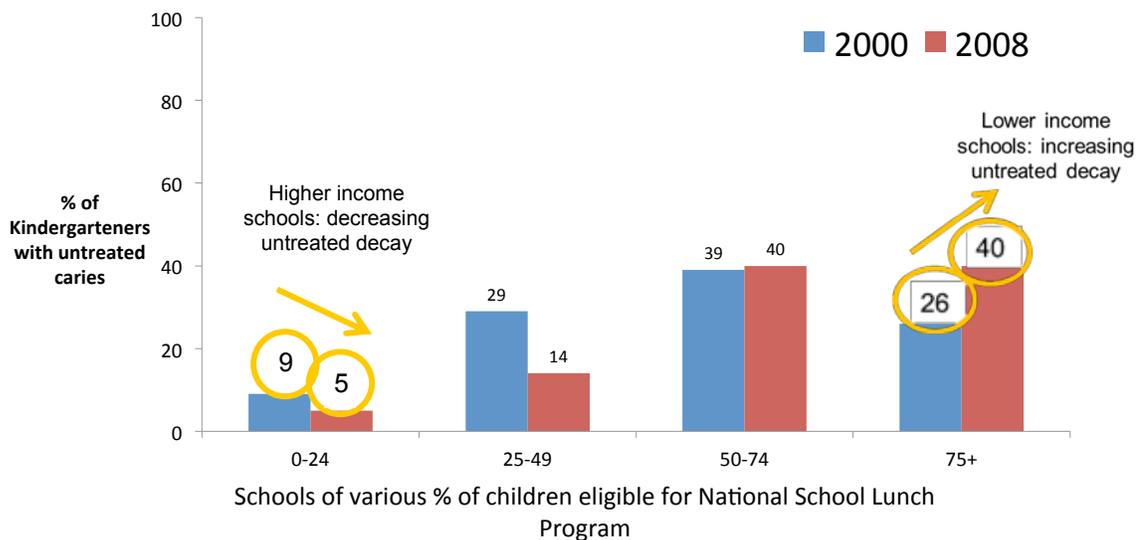
Figure 1: San Francisco has not met HP 2020 goals for children's caries experience



ORAL HEALTH DISPARITIES PERSIST

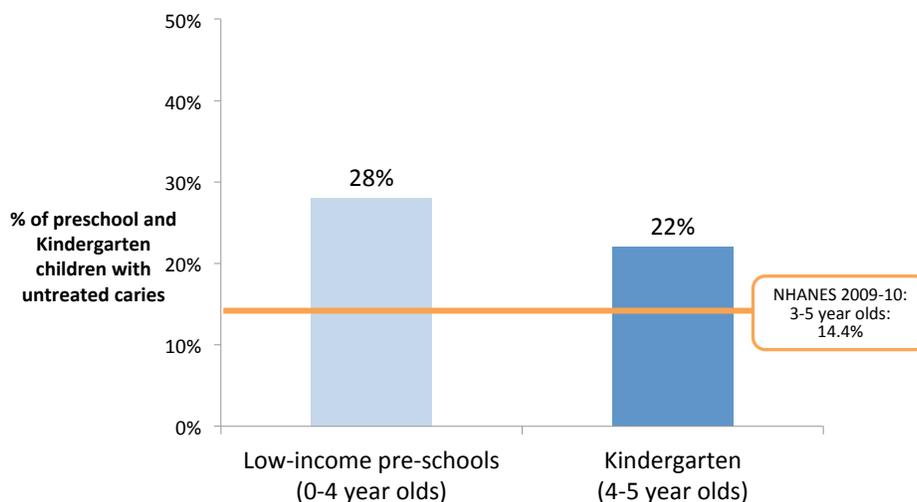
Despite the overall improvements in caries prevalence nationally and locally, there are segments of our youth population that continue to carry the heaviest burden of dental decay. The rate of untreated caries (40%) among kindergarten children in low-income SFUSD schools (schools with high % of National School Lunch Program (NSLP) eligibility) is 8 times higher than the rate found in children from higher income schools (5%). (Figure 2) Moreover, while the prevalence of caries has declined in higher income schools over time, it has increased in low-income schools.

Figure 2: Low income children in San Francisco are 8 times more likely to have untreated caries



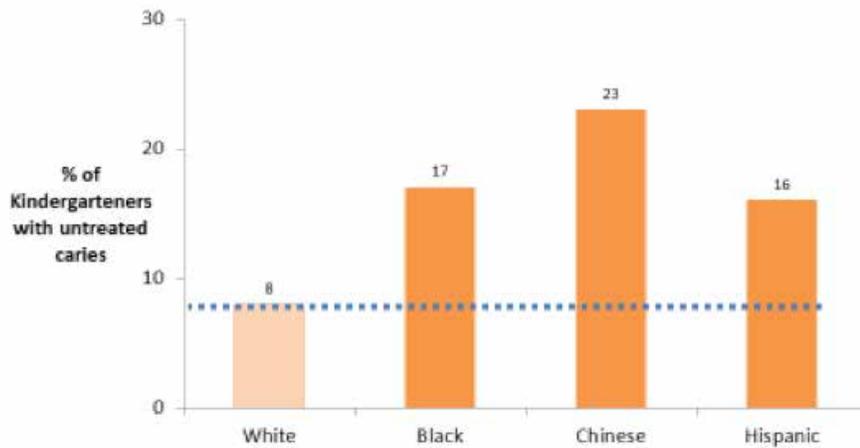
Among our younger low-income children, 28% of preschoolers in state subsidized pre-schools experience dental decay, demonstrating the need for dental care at an early age. (Figure 3)

Figure 3: San Francisco children experience more untreated caries than the national average



SFDPH Child Care Health Project 2011-2012, SFUSD Kindergarten 2010
 CDC/NCHS, National Health and Nutrition Examination Survey, 2009-2010.

Figure 4: Children of color are 2-3 times more likely to have untreated decay in 2012-2013



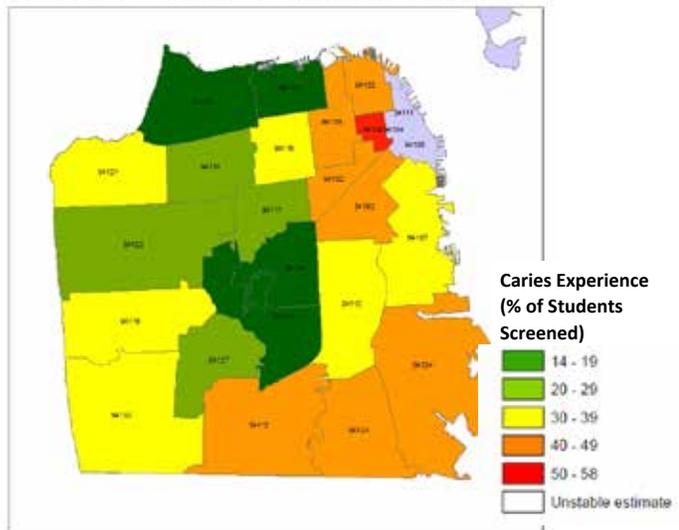
SFUSD: San Francisco Unified School District; Untreated caries: A loss of at least 1/2mm of tooth structure at the enamel surface, with brown coloration of the walls of the cavity. Data represent the proportion of children needing any dental care beyond routine checkups, dental care within the next few weeks for caries without symptoms, or urgent dental care for large carious lesions with pain infection or swelling.
 Data source: San Francisco Kindergarten Dental Screening Project data collected by the SFDPH, SF Dental Society, National Dental Association & SFUSD.

Children who live in some geographic areas, experience 2-3 times the rate of caries as children in other areas of the city. (Figure 5)

Figure 5: Certain San Francisco neighborhoods have 2-3 times more children with caries

- Chinatown
- North Beach
- Nob Hill/Russian Hill/Polk
- Tenderloin
- South of Market
- Bayview/Hunter's Point
- Visitation Valley
- Excelsior
- Portola

Caries experience in San Francisco Kindergarteners



Source: San Francisco Unified School District, Kindergarten Oral Health Screening, 2012-2013.

In addition to these disparities, over half (52%) of Denti-Cal enrolled children in San Francisco did not see a dentist in 2011-12. However, an analysis of data from Denti-Cal and the San Francisco Kindergarten Dental Screening Program shows that Denti-Cal utilization by children ages 0-3 years is significantly associated with reduced prevalence of caries experience among SFUSD kindergarteners one year later.

To address these disparities in oral health and access to dental care, a targeted, coordinated effort, as outlined in this Strategic Plan, is critically important for the health of San Francisco's children.



“It is alarming that the highest burden of children’s dental caries is found in San Francisco Chinatown neighborhoods. If we want to make equitable improvements in our city, we must consider approaches that address this disease not only on an individual level, but also on the family, community, and neighborhood levels that take into account more upstream social and cultural factors.”

Amor Santiago, MPH, Asian Pacific Islanders' Health Parity Coalition

PREVENTION WORKS

The good news is that dental caries is largely preventable. Prioritizing prevention in children is imperative because caries established in childhood increases the risk of dental decay across the lifetime. Population-based strategies, such as community water fluoridation and school-based sealant programs are effective at preventing caries. The widely promoted standards of proper oral hygiene practices and early and routine professional dental care can also increase caries prevention. Our challenge is effective education and promotion, enabling healthy behaviors and care-seeking practices, and providing a supportive physical and social environment for adopting and maintaining these practices.

Best practices for good children's oral health include:

- ✓ Perinatal care and education
- ✓ Dental visit by AGE 1
- ✓ Routine dental visits (2x year based on risk)
- ✓ Limited frequency of sugary foods/drinks
- ✓ Topical fluoride
 - Brushing with fluoridated toothpaste 2x/day
 - Drinking fluoridated water (San Francisco is fluoridated)
 - Fluoride varnish application 2-4x/year
- ✓ Sealants on 1st (6 year old) and 2nd (12 year old) molars
 - ADA recommends sealants for primary teeth too



SAN FRANCISCO'S KINDERGARTEN DENTAL SCREENING PROJECT

Since 2000, a coordinated annual effort organized by the San Francisco Department of Public Health (SF DPH) in collaboration with the San Francisco Dental Society, National Dental Association, and the SFUSD, has been providing dental screenings to all kindergarten children attending SFUSD schools. As the only school district in the diverse city and county of San Francisco, the information obtained from the screenings offers the opportunity to assess and monitor the oral health status of the San Francisco public school kindergarten-age population and identify associated disparities.

“The San Francisco Kindergarten Dental Screening program increases access to care and dental education for a population that may otherwise not see the need for dental care. I am proud to volunteer for a program that gives children and parents the necessary tools to maintain their oral health while providing a positive dental experience.”

John Fong, DDS, San Francisco Dental Society Dentist

SAFETY NET FOR ORAL HEALTH

Most low-income children in San Francisco are eligible for some form of subsidized dental insurance: either Medi-Cal/Denti-Cal, or Healthy Kids Insurance for undocumented or slightly higher income families. In 2015, there will be a new requirement by Covered California, the state's implementation of the Affordable Care Act (ACA) health insurance marketplace, to purchase dental plans for members under age 19. Having dental coverage has proven invaluable to getting needed care for underserved children.

In San Francisco, there are five Federally Qualified Health Center (FQHC) systems that have dental clinics located within their larger clinic. These “Safety Net” dental clinics are where many low-income children and adults receive needed dental care. We also have two university dental schools that offer specialized dental treatment, including hospital dentistry and pediatric dental care.





“Many things influence a child’s progress and success in school, including health. Poor oral health impacts a child’s development and ability to learn. There are too many children in our schools that suffer and are in pain due to dental problems, and a focused and strategic effort to address this is essential for a healthy and successful future for all our children.”

Richard Carranza, Superintendent, San Francisco Unified School District

WHERE CAN WE IMPROVE?

A comprehensive assessment of the current state of San Francisco’s children’s oral health resources, gaps, best practices, and opportunities identified the following areas for improvement:

- 1. Access to dental care.** Compared to our rich medical safety net system which includes FQHC clinics, large hospital/medical clinics, and multiple primary care pediatric private medical offices that accept Medi-Cal, our dental safety net is weak and inadequate. The 50 dental clinics/offices in San Francisco that accepted Denti-Cal in 2011 have decreased to 43 in 2014. At the same time, demand is increasing. As a result of expansion of Medi-Cal under ACA, and the reinstatement of some adult Medi-Cal dental benefits, it is estimated that in 2013-14, 52,000 new San Francisco beneficiaries now have Medi-Cal dental benefits. Without an adequate network of dental providers, we will not be prepared to meet this increased demand for care. Currently children are experiencing 2-3 month wait times at many of our safety net clinics, as availability for dental appointments is becoming more and more limited. Given the insufficient safety net system for oral health in San Francisco, finding strategies to improve access to dental care is of high importance.
- 2. Integration of oral health into primary care.** Because medical providers see children up to 11 times prior to children ever seeing a dentist, ‘well child’ visits are opportunities to provide oral assessments, to apply highly preventive fluoride varnish, and to share key oral health education messages with parents. There are, however, very few clinics and medical providers who offer fluoride varnish to their 0-5 year old patients.

3. **Promotion of the importance of oral health among parents/caregivers and pregnant women.** We not only need to strengthen the dental safety net, we also need to focus on prevention to reduce the need for dental treatment services. Parents'/caregivers' lack of understanding of the importance of preventive oral health care at home and from a dental professional can contribute to their child's risk of developing caries. Because of the rich diversity of San Francisco's population – 35% of the population is immigrants, the largest group from China – it is essential that awareness and knowledge-building efforts be culturally appropriate to effectively promote oral health in communities that have the highest rates of dental caries.
4. **Systematic evaluation of oral health status.** Besides the annual kindergarten dental screening project, we are limited in the collection, analysis, and dissemination of oral health data. More infrastructure is needed to systematically assess and monitor the oral health status of our children citywide.
5. **Coordination citywide.** Over the past decade, dental and medical professional organizations, clinics, universities, San Francisco Unified School District, and community organizations have each launched efforts to improve the oral health of children in San Francisco. To be most effective, we must coordinate these efforts to strengthen advocacy with policy and decision-makers, reduce redundancy, utilize resources efficiently, and ultimately improve our children's oral health efficiently, equitably, and sustainably.
6. **Available revenue stream.** Finally, we are routinely providing some dental services that may be reimbursable, but for which we are not billing. This lost revenue, if successfully obtained, could open the door to self-sustaining projects, and the creation and expansion of new programs for greater reach.

“Although oral health is an important component of whole person care, historically, it has not been well integrated into primary care and we are seeing the consequences of that in our clinics. It is a complex problem that needs multiple approaches including increasing access to care, and decreasing the need for care through better prevention and health promotion interventions.”

Albert Yu, MD, Medical Director, San Francisco Department of Public Health

METHODOLOGY – DEVELOPING A PLAN

An important prelude to the Strategic Plan project was the convening of a group of oral health advocates as part of the San Francisco Health Improvement Partnership (SF HIP) Children’s Oral Health Partnership Working Group in early 2012. This group met three times, with the objective to identify projects that would result in measurable improvements in children’s oral health within five years. The need for coordinated, citywide strategic planning and goal setting was expressed early, and quickly gained strong support and momentum among the group.

With funding from the Metta Fund, a core leadership team was formed and the year-long strategic planning process was underway in the Fall of 2013. A Steering Committee of oral health and children’s health advocates from the community, civic, academic, public, and private sectors was convened to provide leadership to the strategic planning process. Steering Committee members designed the planning process, chaired workgroups, and planned stakeholder retreats. In Fall 2013/Winter 2014, the Steering Committee conducted an environmental assessment of San Francisco children’s oral health status, which identified disparities, strengths and gaps in oral health services, as well as promising practices in prevention and treatment.

Over fifty community and institutional stakeholders attended a full day retreat in January 2014 to review the environmental assessment and advise on the development of the Strategic Plan. Their input helped to select the plan’s main priority areas: Access, Integration with Overall Health, Promotion, Evaluation and Coordination. Over forty retreat attendees and other stakeholders were recruited to join workgroups assigned to these priority areas. The workgroups met in March and April 2014 to develop strategies and tactics. Based on their work, the Steering Committee developed a draft Strategic Plan. In June 2014, community and institutional stakeholders attended a half-day retreat to provide feedback on a draft of the Strategic Plan and develop initial ideas for implementation.

This Strategic Plan was created by the dozens of partner organizations and individuals who will be part of its implementation. The planning process resulted not only in this document but also raised awareness among city and community leaders of the critical importance of oral health, and developed consensus on what must be done to improve children’s oral health status in San Francisco.





VISION

**“ALL SAN FRANCISCO CHILDREN
ARE CARIES-FREE”**

GUIDING PRINCIPLES:

Strategies will focus on:

- ◆ Prevention (not to the exclusion of treatment)
- ◆ Ages 0-10 and pregnant women
- ◆ Populations who are most at-risk, including low-income, communities of color, children with special needs, and recent immigrants
- ◆ Sustainable efforts; utilize all available funding streams
- ◆ Policy and systems levels change
- ◆ Coordinated city-wide efforts
- ◆ Inclusion of community perspective

THREE-YEAR INDICATORS:

To guide our efforts and evaluate our success we have developed the following targets

CARIES EXPERIENCE

1. Reduce the percentage of kindergartners with dental caries experience from 37% in 2012 to 27% in 2017

UNTREATED DECAY

2. Reduce the percentage of kindergartners with untreated dental decay from 16% in 2012 to 8% in 2017

CARIES DISPARITIES

3. Reduce the gap between Chinese, Black and Hispanic/Latino kindergartners and White kindergartners with respect to risk of caries experience from a 20 percentage point difference in 2012 to a 15 percentage point difference in 2017, a relative reduction of 25%.

ACCESS

4. Increase the percentage of children on Medi-Cal under age 10 who received any dental service billed to Denti-Cal during the past year by absolute increase of 10%*
5. Increase the percentage of children on Medi-Cal who have seen a dental provider by age 1, by an absolute increase of 10%.
6. Increase the percentage of women on Medi-Cal that had a dental visit during pregnancy by an absolute increase of 20%

DENTAL SEALANTS

7. Increase the percentage of low-income children in San Francisco Unified School District (SFUSD) aged 7-8 years old who have received dental sealants on their permanent molar teeth by an absolute increase of 10%. (In School Year 2012–2013, sealants applied on 248 second graders.)

*Because Denti-Cal currently does not differentiate preventive from restorative services provided by FQHCs, a baseline for utilizing dental care for preventive services cannot be established. In the future, we would like to be able to use preventive dental services as an indicator.

OVERARCHING STRATEGIES:

To accomplish these objectives, we have identified the following five major strategies:

1. ACCESS

Increase access to oral health care services for San Francisco children and pregnant women

2. INTEGRATION

Integrate oral health with overall health

3. PROMOTION

Increase awareness and practice of optimal children's oral health behaviors among diverse communities in San Francisco

4. EVALUATION

Develop and establish an ongoing oral health population based surveillance system to address the oral health of San Francisco children

5. COORDINATION

Provide coordination and oversight for the implementation of the Strategic Plan



STRATEGY 1: ACCESS

Increase access to oral health care services for San Francisco children and pregnant women. By establishing a sustainable funding stream, expanding service delivery into settings children frequent, increasing the number of safety net dental providers serving low-income children, and expanding case management, we will significantly expand children's and pregnant women's access to dental services.

Tactics:

- 1. Establish a sustainable funding stream.** Develop a feasible mechanism for providers to bill Denti-Cal for dental care delivered outside of the traditional dental office/clinic setting, and disseminate a clearly articulated process to guide safety-net dental providers citywide.
- 2. Increase service delivery to settings children and families frequent** such as Supplemental Nutrition Program for Women, Infants and Children (WIC), Head Start and Early Head Start sites. Provide oral health screenings, parent/caregiver education, fluoride varnish, case management, referrals to dental care.

“I took my 3 year old son to the oral health clinic. With the great experience, we learned about nutritional and dental services available at WIC makes a big difference. This information and dental care for so many children is so important.”

- 3. Expand the oral health program at SFUSD.** Increase the number of San Francisco Unified School District (SFUSD) elementary schools served by the SF DPH sealant program from 9 schools to 12-15 schools, and add 5th grade to the program; expand the kindergarten screening program to include pre-K, and add fluoride varnish applications to the program.
- 4. Expand safety net dental provider capacity to serve low-income young children and pregnant women.** Train and educate future and current dental providers and their support staff to serve children 0-3 years old and pregnant women; train safety net dental programs on portable, school-based health or tele-health modalities; and explore partnerships with Federally Qualified Health Centers (FQHCs) that would allow higher reimbursements for private dental providers.
- 5. Expand Case Management.**

Increase case management for children with dental treatment needs at SFUSD, pre-schools/ Head Start, WIC, as well as through the Child Health & Disability Prevention (CHDP) program.



health screening at WIC. It was a
criticism and correct brushing. Having
all the difference in being able to get
many parents!”

Lilliana Cazares, mother of 3 year old Ethan

STRATEGY 2: INTEGRATION

Integrate oral health with overall health. By integrating oral health promotion and services into primary care well child and pre-natal visits, pregnant women and children are much more likely to receive effective oral health prevention information and services at a time when they can be most effective. This plan calls for system-wide changes as well as education and training of medical providers to significantly expand this promising practice.

Tactics:

- 1. Institute fluoride varnish applications and oral health education in well child pediatric visits and immunizations,** within community clinics and private medical offices targeting underserved neighborhoods.
- 2. Standardize Electronic Medical Records (EMR).** Include oral health questions and management of dental referrals in the EMR system used in medical offices and clinics throughout San Francisco.
- 3. Incorporate oral health care for children more prominently into the Managed Care Health Plans** including Anthem Blue Cross and San Francisco Health Plan (SFHP) programs. Include incentives (i.e., gift cards) for families that receive fluoride varnish and oral health assessments and education for children and pregnant women; incorporate oral health into Practice Improvement Project training for pediatricians and nurses; and consider instituting reimbursement for fluoride varnish.

- 4. Provide trainings and resources to medical providers (MDs, PHNs, CMAs, RNs, CNMs, etc.)** and ancillary support staff in medical offices and clinics (behaviorists, nutritionists, RNs, social workers, CHW, health educators, etc.) to understand the importance of oral health, and to incorporate oral health assessment, referral and application of fluoride varnish into all patient care settings where children’s health and prenatal care is addressed. Provide trainings at regular pediatric medical meetings and grand rounds; promote existing training resources online on professional health organization websites (i.e., Society for the Teachers of Family Medicine, Smiles for Life curriculum); develop detailed protocols to guide implementation of oral health screenings and fluoride varnish in different settings; and incorporate oral health into nursing and medical education and residency training programs.

“At Kaiser Permanente we are implementing oral health skills into our routine well care visits even before the first tooth erupts. By being a bridge to establishing a dental home, we hope we can offer our young members many years of beautiful smiles and overall good health!”

Cecilia Gonzalez, MD, San Francisco Kaiser Pediatrics





STRATEGY 3: PROMOTION

Increase awareness and practice of optimal children’s oral health behaviors among diverse communities in San Francisco. While a variety of oral health promotion efforts exist in San Francisco, their effectiveness will be magnified through coordination, consistent messaging, integration into other health efforts, as well as ensuring that information is created, targeted and delivered in culturally appropriate ways.

Tactics:

- 1. Coordinate oral health education citywide.** Support and expand the efforts of the San Francisco Children’s Dental Health Committee, which coordinates dental health education and dental health fairs in San Francisco. Map current services and education in San Francisco and identify gaps in outreach.
- 2. Integrate oral health promotion into overall health promotion.** Integrate oral health into other DPH health promotion efforts. Include other city departments that target youth through dedicated oral health staff. Join existing social marketing health campaigns and reach out to community lay health worker programs.

3. **Develop and include consistent, culturally relevant messaging** of appropriate health literacy levels aimed toward health-promoting behavior change in all education efforts.
4. **Organize and mobilize most-impacted communities to develop and implement culturally specific oral health education campaigns relevant to their neighborhoods.** Determine oral health education content, develop strategies to reach neighborhood residents, identify key messengers, and determine how to leverage existing resources. Prioritize and target oral health promotion efforts at locations parents/caregivers of children 0-5 and pregnant women frequent, such as food banks, back to school nights, and WIC clinics.



“Our dental clinic accepts the very young child for early dental visits; to educate the parents, and provide preventive care for the baby. Many new immigrant parents do not know about the importance of baby teeth and good oral health, and wait until their child is 3 for the first dental visit. By that time, the child may already have severe tooth decay.”

Cordelia Achuck, DDS, North East Medical Services Dental Director



STRATEGY 4: EVALUATION

Develop and establish an ongoing oral health population-based surveillance system to address the oral health of San Francisco children. Regular and systematic data collection to monitor and evaluate children's oral health outcomes, associated disparities, and progress over time is critical to stakeholders, program planners, and policy makers. Increased capacity for this activity will ensure the development of resources, quality improvement and sustainability of city-wide oral health services that advance the overall goals of the Strategic Plan.

Tactics:

- 1. Increase infrastructure at DPH and SFUSD for data collection, analysis, and dissemination.** Secure additional personnel and dedicated time; establish a committee that includes an epidemiologist from the SF DPH and external members with expertise in oral epidemiology, biostatistics, and program evaluation.
- 2. Identify and prioritize oral health status indicators to be assessed, frequency of collection, and population groups to be assessed in support of the Strategic Plan.** Identify and assess existing oral health data sources for desired information on specific populations; identify and develop data surveillance systems for desired populations not currently assessed for oral health status where desirable and practical to do so, particularly in support of the initiatives recommended throughout the Strategic Plan.



- 3. Coordinate efforts to identify and obtain the resources needed for ongoing data collection and analysis.** Develop mechanisms and data sharing agreements for regular collection of data across institutions; review progress at least annually.
- 4. Document and disseminate annual reports to key stakeholders to build understanding of importance of oral health and inform intervention development and program planning.** Key stakeholders to include SF DPH, SFUSD, dental and medical providers, community partners and citywide policy makers and decision makers.

“When I look in a child’s mouth during a routine exam and find extensive decay, it saddens me to know that these little ones have learned to live with so much disease and discomfort for years and no one has taken care of it. I have found that discussing oral health with the same degree of import as other medical issues during visits helps teach parents how significant this aspect of their child’s wellness is.”

Zeya Malawa, MD, Bayview Child Health Center



STRATEGY 5: COORDINATION

Provide coordination and oversight for the implementation of the Strategic Plan. In order to ensure that the Strategic Plan is implemented and results in real change in the oral health of San Francisco children, a body of committed stakeholders is needed to provide overall guidance and oversight. Having workgroups will help move forward the various strategies and tactics detailed in the Strategic Plan.

Tactics:

- 1. Identify and establish a committee that will provide oversight of the implementation, prioritization, and quality assurance of the Strategic Plan.** Establish a committee to direct and monitor progress in each strategic priority area; develop process for regular monitoring and evaluation of Strategic Plan implementation; facilitate collaboration, coordination, and communication among stakeholders.
- 2. Develop workgroups for each of the strategies to enact the implementation of its tactics.** Identify a chairperson to lead each workgroup; determine priority and implementation steps for each tactic; check-in monthly with the oversight/ coordinating committee.
- 3. Increase infrastructure and staffing at SF DPH to support the coordination of the implementation of the Strategic Plan.** This staff person would be responsible for coordinating meetings; communicating with the San Francisco Health Commission, community stakeholders and DPH administration; and disseminating reports.

APPENDICES:

STRATEGIC PLANNING STEERING COMMITTEE

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STRATEGIC PLANNING WORK GROUPS

ACCESS

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GLOSSARY OF TERMS

- ◆ **Affordable Care Act (ACA):** Legislation, including the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), that expands Medicaid coverage to millions of low-income Americans and makes numerous improvements to both Medicaid and the Children’s Health Insurance Program (CHIP).
- ◆ **Best Practice:** The best clinical or administrative practice or approach at the moment, given the situation, the patient’s or community’s needs and desires, the evidence about what works for this situation/need/desire, and the resources available.
- ◆ **Caries (tooth decay or cavities):** A multifactorial infectious disease that results in the destruction of the tooth structure by demineralization and ultimately cavitation of the tooth surface if left untreated. It is the most common chronic childhood disease, and yet highly preventable.
- ◆ **Caries experience:** any current or past dental caries as defined by having at least one decayed, extracted, or filled tooth due to caries.
- ◆ **Case Management:** A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.
- ◆ **Certified Medical Assistants (CMA):** Multi-skilled practitioners who assume a wide range of administrative and clinical duties in physicians’ offices and other health care settings.
- ◆ **Certified Nurse Midwife (CNM):** Registered nurse with at least a master’s degree in nursing and advanced education in the management of the entire maternity cycle
- ◆ **Early Childhood Caries (ECC):** Any primary tooth in a child under 6 years old that is affected by caries
- ◆ **Federally Qualified Health Centers (FQHCs):** All organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

- ◆ **Fluoride varnish (FV):** A thin coating of fluoride that is applied to tooth surfaces in order to prevent or stop decay. It has been proven effective in infants and children with high risk of decay.
- ◆ **Healthy People 2020:** The federal government’s prevention agenda for building a healthier nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. The overarching goals of Healthy People 2020 are to: attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; achieve health equity, eliminate disparities, and improve the health of all groups; create social and physical environments that promote good health for all; and promote quality of life, healthy development, and healthy behaviors across all life stages.
- ◆ **Head Start:** Head Start is a federal program that promotes the school readiness of children ages birth to 5 from low-income families by enhancing their cognitive, social and emotional development. In addition to education services, programs provide children and their families with health, nutrition, social, and other services.
- ◆ **Indicator:** a quantitative or qualitative expression of a program or policy that offers a consistent way to measure progress toward the stated targets and goals. The data we will measure to determine if we have achieved our result
- ◆ **Managed Care Plans:** Managed care plans are a type of health insurance. They have contracts with health care providers and medical facilities to provide care for members at reduced costs.
- ◆ **National School Lunch Program (NSLP):** a federally assisted meal program operating in public and nonprofit private schools and residential child care institutions. It provides nutritionally balanced, low-cost or free lunches to eligible children each school day. Because income eligibility is a requirement, the percentage of children who qualify for NSLP or “free and/or reduced” lunch program serves as a proxy for income level of a school.
- ◆ **Obstetrics & Gynecology (OB/GYN):** OB for obstetrics or for an obstetrician, a physician who delivers babies. GYN for gynecology or for a gynecologist, a physician who specializes in treating diseases of the female reproductive organs.
- ◆ **Outcomes:** The results of implementing the plan, as experienced by the population.
- ◆ **Public Health Nurse (PHN):** Public health nurses integrate community involvement and knowledge about the entire population with personal, clinical understandings of the health and illness experiences of individuals and families within the population.

- ◆ **Safety Net:** Individuals and organizations that provide health care to low-income and other vulnerable populations, including the uninsured and those covered by public insurance such as Medicaid.
- ◆ **Sealants:** A resin material applied to the chewing surfaces of molar and premolar teeth to prevent caries.
- ◆ **Strategy:** A carefully designed oral health plan of action for obtaining a specific goal or outcome.
- ◆ **Tactic:** An action implemented as one or more specific tasks for carrying out a strategy
- ◆ **Women, Infants and Children (WIC):** The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides Federal grants to States for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.

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