

**Testimony**  
**Health Services Committee**  
**Wednesday, October 30, 2013 – 10:30 a.m.**  
**North Dakota Department of Health**

Good morning, Madam Chair and members of the Health Services Committee. My name is Kim Mertz and I am the Director of the Division of Family Health for the North Dakota Department of Health. I am here today to provide a presentation regarding dental programs available through the department; oral health needs assessment documents prepared as part of the federal grant process; and the status of Centers for Disease Control and Prevention (CDC) grant funding.

Dental programs available through the department include:

Donated Dental Services Program

Supported through state general funding (\$50,000 per biennium), the Donated Dental Services Program provides dental care through a network of 141 North Dakota volunteer dentists and 29 dental laboratories to the state's most vulnerable people- the disabled, elderly or medically-compromised individuals who cannot afford necessary treatment. The program is a partnership between the North Dakota Dental Association and the North Dakota Department of Health in cooperation with Dental Lifeline Network. Since the program's inception in 2000, 671 North Dakota residents have received more than 2 million in donated dental therapies.

Smiles For Life Fluoride Varnish Program

During the 2007 legislative session, HB 1293 was passed allowing physicians, physician assistants, registered nurses, licensed practical nurses and advanced practice registered nurses the ability to apply fluoride varnish upon the completion of a fluoride varnish curriculum approved by the North Dakota Board of Dental Examiners. Smiles for Life (module 6) is the current, on-line oral health training curriculum approved for this program. Since 2008, many local public health units, clinics and Head Start entities are applying fluoride varnish to children's teeth.

School-based Fluoride Varnish and Seal!ND (Sealant) Program

In 2009, HB 1176 was passed authorizing general supervision of licensed dental hygienists for procedures authorized in advance by a dentist. As a result of this legislation, the Oral Health Program implemented a school-based fluoride varnish and sealant program (Seal!ND). In fall 2011, four public health hygienists employed by the Department of Health and supported through a Health Resources and Services Administration (HRSA) Workforce grant, began applying fluoride varnish and dental sealants to children pre-kindergarten through sixth grade in approximately 50 schools throughout the state. In some schools, small numbers of students in grades 7 through 12 were served as well. Since 2011, approximately 1,700 students per school year have

received services through this program. Despite program success, the Oral Health Program did not receive continued funding from the HRSA Workforce grant. HRSA funding over the last three years was about \$260,000 per year. Consequently, three public health hygienist positions and a data entry position have been eliminated (all temporary positions), resulting in a significant reduction of school-based services. Only one public health hygienist will be able to provide services to about 180 students in three schools this year. In addition, collaborative projects through contracts with the Ronald McDonald Care Mobile to assist with program costs and Bridging the Dental Gap to support dental services in long-term care facilities have not been continued.

The Oral Health Program did receive another five-year (2013-2018) CDC State Oral Disease Prevention Program grant. However, funding for year one of the grant is only \$150,000. Previous CDC funding levels for the last five year grant cycle averaged \$310,000 per year. CDC has indicated that funding will increase to \$250,000 for years 2-5 of the grant cycle. This CDC grant supports state level program staff essential for developing and enhancing the infrastructure and capacity of the oral health program in eight required component areas. These eight components include oral health program leadership; a surveillance system to monitor oral diseases and a report on the state's burden of oral disease; a state oral health plan; a statewide oral health coalition and strong partnerships to increase program resources; evidence-based prevention programs including community water fluoridation and school-based sealant programs; policy and health system strategies; collaboration with other state chronic disease programs; and program evaluation. Due to the decrease in this funding, state staff have had changes in their roles and responsibilities. Most noticeable is the reduction in prevention efforts, oral health epidemiology and administrative assistant support.

An oral health needs assessment was required for both the HRSA and CDC grants that were submitted this year (see Attachments 1 and 2). For your information, I have also distributed the document *Oral Health in North Dakota – Burden of Disease and Plan for the Future (2012-2017)*.

This concludes my presentation. I am happy to answer any questions you may have.

Needs Assessment for the  
Health Resources and Services Administration  
Oral Health Workforce Activities Grant Application  
April 2013

***Geographic Distribution***

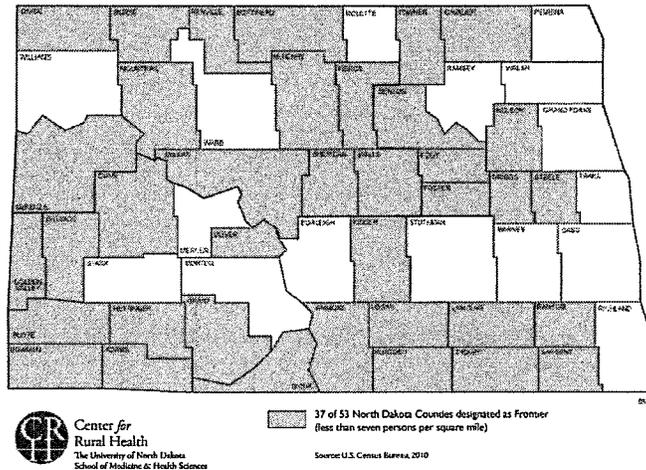
ND is an agricultural state located in the geographic center of the United States between Montana and Minnesota, adjacent to the Canadian provinces of Saskatchewan and Manitoba. It encompasses significant land and water area (70,689 square miles) divided into 53 counties and spread over four distinct regions; the southwestern Great Plains (badlands), northwest Missouri Coteau (plateau), central Glaciated Plains, and eastern border Red River Valley (US Census, 2012). Health equity is confronted by a variety of challenges including the unique geography and climate, demographics, and socioeconomic factors of the state.

***Population Characteristics***

The state population has increased by five percent since 2000, reaching 672,590 in 2010, and obtaining a state population density of 10 persons per square mile (US Census, 2013). However, energy development activity in western ND has significantly changed historical population trends within the state. The impact, which started in 2006, altered migration flows. More than half of the western counties in the state began experiencing population growth. Between 2011 and 2012, ND became the fastest growing state in the U.S. growing at two percent, three times the national average. Additionally, several high-growth micro areas in ND have emerged in the top ten fastest-growing in the nation (Williston-1<sup>st</sup>, Dickinson-4<sup>th</sup> and Minot-8<sup>th</sup>). Population estimates indicate that ND reached 699,628 in 2012. Forecasts indicate that the population boom will continue into 2025 when the state's population is projected to reach nearly 842,000 (NDHFA, 2012).

The ND population distribution is nearly equal between rural (46%) and urban (54%) counties (US Census, 2011). However, the majority of North Dakota counties (29) have fewer than 5,000 residents and are referred to as "frontier" counties defined as having a population density of six or fewer residents per square mile (US Census, 2011). This creates important issues regarding access to health services by residents and the challenges of delivering of health services to a very sparsely populated state.

## North Dakota Frontier Counties



The racial and ethnic mix in ND is changing modestly. Over the past 20 years, the proportion of the state's population that is white declined from 96 percent to approximately 90 percent. ND has four American Indian reservations. American Indians comprise the largest minority group in the state, representing five percent of the state's population base in 2010 (US Census, 2013). More than 5,500 refugees have been resettled in ND from 1997 through 2012, a population representing 39 countries. Most of the refugees arriving in the state are resettled in four of the state's largest cities (Fargo, West Fargo, Grand Forks, and Bismarck) (LSSND, 2013).

ND population age distribution indicates that the male/female ratio is approximately equal. 2011 age distribution estimates indicate that approximately seven percent of the ND population is less than five years of age, 22 percent is under 18 years of age and nearly one in seven (14%) of the population is elderly (65 years of age or older) (US Census, 2013). Projections indicate that the number of elderly in the state will increase by 52 percent by 2025. This trend is largely due to the baby boomers aging into the elderly cohort (US Census, 2011). Most elderly are on fixed incomes and often lack oral health insurance or are on Medicaid and cannot find providers who will accept Medicaid.

### ***Oral Disease Burden***

The burden of oral disease is not uniformly distributed throughout populations and age groups in ND. A significantly higher proportion of minority children have decay experience, untreated tooth decay and urgent dental needs. Over one in five (21%) HeadStart children (ages 2-4) have untreated caries (DHS, 2009). The same percentage of third-grade students (ages 8-9) assessed have untreated caries. One fourth of children with an identified special need (23%) needed other dental care beyond a preventive dental visit.

American Indian children experienced more dental caries (tooth decay) than whites (81% vs. 49%). They also had more untreated dental decay (39% vs. 17%). While nearly three-fourths (74%) of American Indian children had dental sealants, rampant decay was three times more prevalent in American Indian children than in white children (29% vs. 9%). Forty-one percent of American Indian children reported to not have brushed their teeth on the day of the assessments, and 16 percent reported to not have their own toothbrush (NDDoH, 2011).

Anecdotal reports indicate the children receive sealants in school-based programs, but parents do not follow up with needed restorative care for a variety of reasons including lack of transportation, unable to find child care, inflexible work schedules, no insurance/inability to pay for care and low oral health literacy among parents/caregivers. Children in rural areas were also more likely to have untreated tooth decay compared to children in urban areas (28% vs. 17%). Children in schools with greater than 50 percent of children on the free and reduced-fee lunch program were more than three times as likely to have rampant tooth decay (20% vs. 6%) and were more than twice as likely to have untreated tooth decay (32% vs. 15%) compared to children in schools with less than 25 percent of children on the program (NDDoH, 2011).

ND adolescents are at risk for dental caries. In 2011, over two-fifths of middle school students (42%) and more than half of high school students (57%) reported to have had at least one cavity. Approximately one in four middle school students (25%) and high school students (24%) reported not having had a dental visit within the previous 12 months (YRBS, 2011).

More than one-fourth of ND adults (29%) reported to have not visited a dentist or dental clinic within the past year; nearly one in twelve (8%) had not made a visit within five or more years. There is an inverse relationship between income level and permanent tooth loss; nearly one in six adults with a reported annual income of less than \$15,000 had lost all of their teeth due to tooth decay or gum disease (16%) (BRFSS, 2010).

The oral health needs of ND older adults are multivariate. Over one in three adults 65 and older (35%) reported to have not been to a dentist within the past year. Furthermore, 31 percent reported to have not had a teeth cleaning within the past 12 months. Nearly one in five older adults (19%) reported to have lost all of their teeth due to tooth decay or gum disease (BRFSS, 2010). Long-term care residents in skilled care facilities have unique oral health needs. Nearly one in three (32%) had one or more identified oral health problems. Over one in three (35%) are missing all of their teeth. Over half (54%) have a partial denture and over one in three (37%) have both an upper and lower denture. Of those with teeth, nearly one-half (43%) had one or more identified oral health problem (BSS, 2012).

For many ND women, obtaining oral health care may be a challenge. Poverty and lack of insurance can be significant barriers. Approximately one in seven ND females are estimated to live in poverty (14%) and nearly one in ten lack health insurance (9%) Of all households in the state, six percent were led by single mothers (CSR, 2013).

Oral disease has shown to be associated with chronic disease and birth complications. Nearly one-third of all women (32%) had not had their teeth cleaned by a dentist or dental hygienist in the previous year. More than one-third of women with an annual household income less than \$15,000 had not had a dental visit for at least two years and nearly one-third had not had a teeth cleaning in two or more years. Nearly two-thirds of women with this income lost six or more teeth due to decay or disease. More than one-third of individuals in ND (41%) with a disability had not visited a dentist or dental hygienist within the last year, compared to one-fourth (25%) of individuals with no indicated disability (BRFSS, 2010).

### ***Socioeconomic Disparities-Economic Conditions***

ND's robust economy has created an economic contradiction that highlights the challenges in socioeconomic disparities within the state. For example, the oil boom in the western part of the state combined with a strong agricultural economy has placed ND in the top two states for Gross State Product growth (leading indicator of a state's economy) among all states in the past four years and per capita income growth in the past two years. Additionally, ND has consistently had among the lowest unemployment rates in the nation. In contrast, an estimated 12 percent of residents in the state live in poverty (CSR, 2013).

The disparity becomes more apparent when one focuses on select groups. One in four American Indians in the state are impoverished including nearly half of American Indian children under the age of 18. Over 38 percent of children living in single parent families are below the poverty threshold. Statewide, an average of approximately one in three children (33%) enrolled in school statewide received free and reduced-fee school lunches. One in five senior homeowners in the state (age 65 or older) are cost-burdened and paying more than 30 percent of their income toward housing cost. This proportion jumps to 49 percent for seniors who rent their home. Residents with limited resources have limited ability to afford oral health care. Moreover, access to oral health by those with limited resources compounds the problem and underscores the challenge for ND. Comparison of the cost of living between the eastern (Fargo-Moorhead metro) area and western (Minot micro) area of the state indicates that costs for the western region are much higher for categories of housing, transportation, healthcare, and goods and services (CREC, 2013).

While most North Dakotans have some form of health insurance, many residents are without coverage. The percentage of all uninsured ND residents has increased to 12 percent. The proportion of uninsured among residents ages 1 through 17 is 10 percent, ages 18 through 39 is 26 percent, ages 40 through 49 is 19 percent, and ages 50 through 64 is 14 percent. Nearly all residents ages 65 and older were covered by some form of health insurance (98%), which is nearly one in seven ND residents (CPS, 2012).

Medicaid is the primary source of health care for low-income families, the elderly and people with disabilities in the U.S. However, with the current shortage of dental providers and the productive schedules, there must be additional incentive to accept Medicaid patients. ND ranks in the lowest quartile for the percentage of children receiving preventive dental services in the Medicaid program. Only 28 percent of enrolled children received preventive dental services and only 31 percent received a dental service (NDDHS, 2012).

### ***Dental Workforce and Public Health Programs***

The state is characterized by a chronic shortage of health professionals in rural areas. In 2010, there were .61 dentists per 1,000 population, compared to the national estimate (.76). 2013 dentist licensure data indicates that a majority (67%) of all licensed dentists reside in the four largest ND counties (Burleigh, Cass, Grand Forks, and Ward) with the four largest ND cities (Bismarck, Fargo, Grand Forks, and Minot); 42 of the 53 ND counties have six or fewer practicing dentists (79%). This data also indicates that 17 ND counties (32%), equating to more than 50,000 people, were lacking a dental provider residing in that county altogether (NDSBDE, 2013).

In 2013, the number of licensed dentists in ND has increased to 436, with 380 residing in the state. This number has increased 15% over the past 5 years (2008-2013). Only six were reported as specialized in pediatrics (2%). Over one-third (36%) of dentists practicing in the state reported that they anticipate retirement from full-time practice within the next 15 years. Over one-half of the dentists reported to accept Medicaid patients (53%), although a strong majority (77%) will not accept all Medicaid patients that present for treatment.

Unfortunately, ND does not have a dental school offering Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) education. The North Dakota State College of Science is the only college within the state to provide dental education resulting in an Associate in Applied Science (A.A.S.) in Dental Hygiene, Associate in Applied Science (A.A.S.) in Dental Assisting or a Dental Assisting certification program. Currently, the school only has room to admit 26 dental hygiene and 20 dental assisting students annually. The college is located in Wahpeton, close to the border with Minnesota, and draws in students from several states (NDSCS, 2013).

Healthy Smiles Fluoride Varnish and Seal! ND are key preventive programs of the ND Oral Health Program. In 2007, the ND Legislature passed a law that allows fluoride varnish to be applied by medical professionals. Applications are reimbursed by Medicaid twice a year up to age 21. NDDoH PHHs provide fluoride varnish to school children. Over 10,000 screenings and applications have been provided to children in ND through these programs since 2008 (NDDoH, 2013).

Seal! ND is a program established in 2008 designed to increase access to preventive dental care to underserved populations. The program provides dental sealants to children’s molars to help prevent dental decay and is an important component of oral health surveillance. During the 2011-2012 school year, 768 sealants were applied to school children by the NDDoH PHHs (NDDoH, 2013).

**North Dakota Health Professional Shortage Areas and Resources**

Nineteen out of 53 ND counties (36%) are designated as dental HPSAs; the majority of those counties (58%) are located in the rural western part of the state.



Federally Qualified Health Centers (FQHCs), including Community Health Centers (CHCs) provide family-oriented primary and preventive oral healthcare services for people living in rural and urban medically underserved communities. Data reported by ND FQHCs indicates that 9,314 people received dental services in 2011. ND currently only has five oral health safety-net providers, including three FQHCs that provide dental care. BDG, a private nonprofit safety-net clinic, provided 6,700 patient encounters in 2011. Another safety-net provider, the RMCM, initiated service in 2012 and served 796 children. However, 19 of the 53 ND counties (36%) remain designated as dental HPSAs. This indicates that in much of ND, dentists are overworked or inaccessible. In addition, county full-time equivalent dentist ratios of 5,000:1 exist within these areas (HRSA, 2011). There are no stationary safety-net clinics in the western part of the state. The Care Mobile travels to communities to bring the care to children in the western half of the state.

ND has policies in place to try to attract dentists to the rural and underserved areas and improve access to care such as the rural dental loan repayment program and allowing medical professionals to apply fluoride varnish. The rural geography, distribution of providers, transportation barriers for families, inability to afford care, parents inflexible work schedules and low oral health literacy all impact access to oral health care.

Needs Assessment for the  
Centers for Disease Control and Prevention  
State Oral Disease Prevention Program Grant Application  
May 2013

***Problem/Need:***

The burden of oral disease is not uniformly distributed throughout North Dakota. Access to oral health services is an ongoing concern and challenge. Vulnerable and underserved populations face a variety of barriers to oral health care including transportation issues, lack of insurance or ability to pay for care, inability to take time off work to go to the dentist or transport their children, limited availability of providers accepting Medicaid and lack of understanding of the importance of good oral health and its impact on overall health. The limited oral public health infrastructure, particularly in rural counties and lower economically impacted state regions, provides limited options for families in need. The existing oral health safety-net facilities are overburdened and cannot take on more patients without expanding their infrastructure.

The Oral Health Program has implemented the enhancement of the community water fluoridation program and expansion of the school-based sealant program. North Dakota is pursuing a number of new policy/environmental changes to increase our ability to promote and protect the oral health of our most vulnerable residents. These initiatives promote medical/dental collaboration, focus on increasing oral health literacy and investigate new delivery models/expanded scope of practice.

***Geographic Distribution*** - North Dakota is an agricultural state located in the geographic center of the United States. It is the 19<sup>th</sup> largest state by geographic size (70,698 square miles) and is divided into 53 counties (U.S. Census, 2012). The majority of North Dakota counties (29) have fewer than 5,000 residents. Overall, the state's population density is 10 people per square mile with 70 percent of the counties in the state labeled "frontier" counties, which are defined as having a population density of six or fewer residents per square mile (U.S. Census, 2011). Access to oral health and the challenge of delivering services to a large, yet very sparsely populated state is a paramount issue for North Dakota.

***Population Characteristics*** - Population estimates indicate that North Dakota reached 699,628 in 2012, a 4 percent increase from 2010 (U.S. Census, 2012). Energy development activity in western North Dakota has significantly changed historical population trends within the state since 2006. From 2011 to 2012, North Dakota became the fastest growing state in the United States growing at 2.2 percent, three times the national average (U.S. Census, 2012).

***Oral Disease Burden*** - Disparities in oral health exist among specific population and age groups in North Dakota. A significantly higher proportion of minority children have decay experience, untreated tooth decay and urgent dental needs. One in six (16%) Head Start children (ages 2-4) need dental treatment (Program Information Report, 2012). One in five (21%) third-grade students (ages 8-11) assessed has untreated caries. One fourth of children with an identified special need (23%) needed other dental care beyond a preventive dental visit (Basic Screening Survey, 2010).

Racial disparities in oral health present new challenges to oral health providers as these distributions change. Over the past 20 years, the proportion of the state's population that is white declined from 96 percent to approximately 90 percent. American Indians comprise the largest minority group in the state, representing 5 percent of the state's population base in 2010 (U.S. Census, 2013). American Indian children in third grade experienced more dental caries (tooth decay) than white children (81% vs. 49%). They also had more untreated dental decay (39% vs. 17%). While nearly three-fourths (74%) of American Indian children had dental sealants, rampant decay was three times more prevalent in American Indian children than in white children (29% vs. 9%) (Basic Screening Survey, 2010).

Third-grade children in rural areas were more likely to have untreated tooth decay compared to children in urban areas (28% vs. 17%). Children in schools with greater than 50 percent of children on the free and reduced-fee lunch program were more than three times as likely to have rampant tooth decay (20% vs. 6%) and were more than twice as likely to have untreated tooth decay (32% vs. 15%) compared to children in schools with less than 25 percent of children on the program (Basic Screening Survey, 2010).

North Dakota adolescents are at risk for dental caries. In 2011, over two-fifths of middle school students (42%) and more than half of high school students (57%) reported to have had at least one cavity. Approximately one in four middle school students (25%) and high school students (24%) reported not having had a dental visit within the previous 12 months (Youth Risk Behavioral Survey, 2011).

More than one-fourth of North Dakota adults (29%) reported to have not visited a dentist or dental clinic within the past year; nearly one in 12 (8%) had not made a visit within five or more years. There is an inverse relationship between income level and permanent tooth loss; nearly one in six adults with a reported annual income of less than \$15,000 had lost all of their teeth due to tooth decay or gum disease (16%) compared to 2 percent of adults with incomes of \$50,000 or more (Behavioral Risk Factor Surveillance System, 2010).

The oral health needs of North Dakota older adults are multivariate. One in three older adults (35%) has reported to have not been to a dentist within the past year. Furthermore, 31 percent reported to have not had a teeth cleaning within the past 12 months. Nearly one in five older adults (19%) reported to have lost all of their teeth due to tooth decay or gum disease (BRFSS, 2010). Long-term care residents in skilled care facilities have unique oral health needs. One in three (32%) had one or more identified oral health problems and one in three (34%) was missing all of their teeth. Of those with teeth, nearly one-half (43%) had one or more identified oral health problem (BSS, 2012).

***Socioeconomic Disparities-Economic Conditions*** - North Dakota's robust economy has created an economic contradiction that highlights the challenges in socioeconomic disparities within the state. North Dakota has consistently had among the lowest unemployment rates in the nation for the past several years (Bureau of Labor Statistics, 2013). In contrast, an estimated 12.3 percent of residents in the state live in poverty (U.S. Census, 2013).

Approximately 40 percent of North Dakota children living in single-parent families are below the poverty threshold. Among American Indians in the state, approximately 42 percent are impoverished including half of American Indian children younger than the age of 18 (U.S. Census, 2011). Statewide, an average of approximately one in three children (32%) enrolled in school received free and reduced-fee school lunches (NDDPI, 2012).

While most North Dakotans have some form of health insurance, many residents are without coverage. Approximately one in 10 North Dakota residents was uninsured in 2010 (11.4%) (Small Area Health Insurance Estimates, 2012). Medicaid is the primary source of health care for low-income families, the elderly and people with disabilities in the United States. However, with the current shortage of dental providers and the productive schedules, there must be additional incentive to accept Medicaid patients. North Dakota ranks in the lowest quartile for the percentage of children receiving preventive dental services in the Medicaid program. Only 28 percent of enrolled children received a preventive dental service and only 14 percent received a dental treatment service (Centers for Medicare and Medicaid Services form 416, 2012).

***Dental Workforce and Public Health Programs*** - The state is characterized by a chronic shortage of health professionals in rural areas. In 2010, there were .61 dentists per 1,000 population, compared to the national estimate of .76. The 2013 North Dakota State Board of Dental Examiner dentist licensure data indicates that a majority (67%) of all licensed dentists reside in the four most populated North Dakota counties (Burleigh, Cass, Grand Forks and Ward) with the four largest North Dakota cities (Bismarck, Fargo, Grand Forks and Minot); 42 of the 53 North Dakota counties have six or fewer practicing dentists (79%). The data also indicates that 17 North Dakota counties (32%), equating to more than 50,000 people, were lacking a dental provider residing in that county (North Dakota State Board of Dental Examiners, 2013).

North Dakota has 380 licensed dentists residing in the state and only six (2%) were reported as specialized in pediatric dentistry (NDSBDE, 2013). 2011 North Dakota Department of Health Dental Workforce Survey data identified that over one-third (36%) of the responding dentists practicing in the state reported that they anticipate retirement from full-time practice within the next 15 years. Over one-half of the dentists reported accepting Medicaid patients (53%), although a strong majority (77%) have existing criteria for the Medicaid patients they will accept (NDDWS, 2011).

Unfortunately, North Dakota does not have a dental school. The North Dakota State College of Science is the only college within the state to provide allied dental education resulting in an Associate in Applied Science in Dental Hygiene, Associate in Applied Science in Dental Assisting or a Dental Assisting certification program (NDSCS, 2013). Healthy Smiles Fluoride Varnish and Seal! North Dakota are key preventive programs of the Oral Health Program. In 2007, the North Dakota Legislature passed a law that allows fluoride varnish to be applied by medical professionals. Applications are reimbursed by Medicaid twice a year up to age 21. North Dakota Department of Health public health hygienists provide fluoride varnish to school children. Seal! North Dakota is a school-based program established in 2008 designed to increase access to preventive dental care to underserved populations. The program provides dental sealants to children's molars to help prevent dental decay.

***North Dakota Health Professional Shortage Areas and Resources*** -Twenty out of 53 North Dakota counties (38%) are designated as geographic or low-income dental health professional shortage areas; the majority of those counties (55%) are located in the rural western part of the state (CRH, 2012).

North Dakota currently only has five oral health safety-net providers, including three Federally Qualified Health Centers, one private nonprofit safety-net clinic and one dental care mobile that provide dental care. There are no stationary safety-net clinics in the western part of the state. The dental care mobile travels to communities to bring the care to children in the western half of the state.

North Dakota has policies in place to try to attract dentists to the rural and underserved areas and improve access to care such as the rural dental loan repayment program and allowing medical professionals to apply fluoride varnish. In addition, a new medical/dental collaborative is focusing on engaging medical practitioners in oral health assessment and referral, and anticipatory guidance. The rural geography, distribution of providers, transportation barriers for families, inability to afford care, parents' inflexible work schedules and low oral health literacy all impact access to oral health care.