Comprehensive populations make them a key area for integrating oral health into wide reach of FQHCs and their importance to underserved federally qualified health clinics is increasing in most regions.

The proportion of patients receiving oral health services at core leadership team is replicating a campaign to increase support that resulted in over 2,000 points of contact with lawmakers, the Medicare does not include an extensive dental benefit, but efforts to increase support are underway. Building on a Florida pilot that resulted in over 2,000 points of contact with lawmakers, the core leadership team is replicating a campaign to increase support for Medicare dental benefit in Iowa, Michigan, and Tennessee.

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Since 2015, six of the ten largest school districts have participated in a learning community to develop and scale their oral health models. These six districts are also working to implement education, prevention, and treatment services district-wide. Four of the six are developing sustainability strategies to support oral health integration.

Since 2014, nine states increased their benefit levels for adult Medicaid recipients. California and Illinois made the greatest strides over this time period by increasing their benefit levels from emergency to extensive. As of July 2018, eighteen states offer extensive benefits.

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2018 UPDATE

NATIONAL PROGRESS ON THE ORAL HEALTH 2020 TARGETS
**DASHBOARD**

**Oral Health 2020** is a multi-year effort to strengthen and unify the Oral Health Progress and Equity Network (OPEN), build upon current initiative strategies, and expand impact. In 2014, the OPEN (formerly known as the Oral Health 2020 Network) determined six key goals on which to collectively focus its work. The Network recognizes that addressing these goals requires long-term commitment and continuous work. To make efforts more tangible, they identified targets related to each goal to be achieved by 2020.

The Oral Health 2020 dashboard is a data-rich, cohesive illustration of progress toward the seven Oral Health 2020 targets. Its purpose is to provide an annual update on key metrics related to the Oral Health 2020 targets, as well as information about recent work and accomplishments that are contributing to gains. The dashboard also serves as a tool for OPEN members to promote success and reflect on their work in the context of overall progress toward all Oral Health 2020 targets.

This report expands upon the information included in the dashboard. It provides a brief overview of the status of Oral Health 2020 goals and targets, followed by a summary of recent accomplishments and the role network members are playing to advance progress.

The dashboard and this accompanying report were developed for two key audiences: 1) the Board of Directors and 2) OPEN members. We encourage these audiences to share the dashboard and this report with their networks to advance learning about oral health and encourage more organizations and advocates to support Oral Health 2020 efforts.
ORAL HEALTH 2020 GOALS & TARGETS

**Eradicate dental disease in children**
2020 Target: With the closing of disparity gaps, 85% of children reach age 5 without a cavity

**Incorporate oral health into primary education**
2020 Target: The 10 largest school districts have incorporated oral health into their systems

**Include an adult dental benefit in publicly-funded coverage**
2020 Target: At least 30 states have an extensive Medicaid adult dental benefit
2020 Target: Medicare includes an extensive dental benefit

**Build a comprehensive measurement system**
2020 Target: A national and state-based oral health measurement system is in place

**Integrate oral health into person-centered care**
2020 Target: Oral health is integrated into at least 50% of emerging person-centered care models

**Improve the public perception of the value of oral health**
2020 Target: Oral health is increasingly included in health dialogue and public policy
More children are reaching age 5 without a cavity, but caries rates are higher for Black, Latino, and American Indian children.

Tooth decay affects more than one in five children between ages two and five. The Centers for Disease Control and Prevention (CDC) reports that the rate of tooth decay, or caries, in the baby teeth of children ages two to five increased by five percentage points from the period 1988-1994 to 1999-2004.\(^1\) Since then, however, the curve has reversed. From the period 1999-2004 to 2015-2016, the rate of caries in children dropped by 7 percentage points. According to the most recent data, 79 percent of children reach age five without a cavity.\(^2\)

Although caries prevalence has decreased overall, more work is needed to address disparities. Caries prevalence is higher among Hispanic and non-Hispanic Black children than White children. While 70 percent of White children ages two to eight were free from caries in 2011-2012, only 56 percent of non-Hispanic Black children and 54 percent of Hispanic children were free from caries.\(^3\) Rates of tooth decay are even higher among American Indian and Alaska Native children – more than four times greater than their White Non-Hispanic peers.\(^4\)

* Note: Race/ethnicity data cover ages two to eight and come from the previous NHANES reporting period, 2011-12. Data by race/ethnicity are not available for children ages two to five.
DentaQuest Foundation’s partners and grantees are working to ensure that children have access to oral health coverage

Experts cite the recent increase in children’s oral health coverage as a key contributor to the decrease in childhood caries. The largest increase in coverage has occurred through the growth in enrollment in Medicaid and the Children’s Health Insurance Program (CHIP). Between 2013 and 2016, the percent of eligible children enrolled in these two programs increased from 89 percent to 94 percent.5

OPEN members have played an important role in helping ensure that eligible children receive comprehensive and continued access to oral health services.

In 2018, the Children’s Dental Health Project and other OPEN partners worked with the federal Centers for Medicare and Medicaid Services (CMS) to obtain written policy guidance in the form of an Informational Bulletin that clarifies that all children enrolled in Medicaid and CHIP should have access to the individualized oral health services that their providers recommend, regardless of the cost of care.

OPEN members also participated in various efforts encouraging the reauthorization of CHIP, which passed in January 2018.6 In addition to authorizing funding for six more years, the new law enhances nationwide data collection for children’s preventive dental care. This will deepen the collective understanding of access and utilization disparities across racial and other groups.

Medical and dental providers are working together to ensure children access oral health care

OPEN members across the country are encouraging pediatricians to promote visits to the dentist. For instance, members in New Mexico and California are testing innovative approaches to promote more systemic medical-dental collaboration.

The Albuquerque Area Dental Support Center, in collaboration with the Indian Health Services’ Early Childhood Caries Collaborative, is piloting and scaling the Prescription for Oral Health model, which provides oral health prescription pads to pediatric primary care providers.7 Providers hand these informal “prescriptions” to families to reinforce the importance of making dental appointments for their children.

A Medical-Dental Collaboration Pilot has demonstrated positive results for young children in Los Angeles. With the leadership and support of Children Now, the DentaQuest Foundation, and First 5 Los Angeles, this three-year pilot project aims to encourage children aged zero to five to see a dental provider during well visits at participating pediatric clinics. The pilot focused on children who had not had a dental visit in the previous twelve months. Through this collaboration and the newly-established referral process, nearly six in ten children (58 percent) visited a dentist within six months of their doctors’ visit. The model is now being replicated in communities across California.8

Eradicate dental disease in children
School districts are actively participating in a learning community to develop and scale their oral health models.

School-based oral health services can provide children with reliable and inclusive oral health care by leveraging school sites as entry points for accessing services. Since 2015, School-Based Health Alliance has worked to engage the ten largest school districts, which represent 10 percent of all school-aged children in the US, to build and sustain comprehensive school-based oral health models. Six of the ten largest school districts are involved with the School-Based Health Alliance’s learning community and are working to develop a comprehensive oral health model. This year, the group articulated their model in an Organizational Framework that includes education, screening, preventive care, care coordination and linkages, and treatment in schools.

Four of the six participating districts are also working on sustainability policies to fund, measure, and sustain the work. In New York, the Public Health Department has partnered with the school district on a comprehensive oral health strategy. The LA Trust is engaged in a data collection system-wide effort to measure and improve outcomes in Los Angeles schools. In Las Vegas, the Clark County Unified School District is advocating for improved oral health policies, including changes to reimbursement rates. In Chicago Public Schools, partners are creating a fully-integrated oral health curriculum to accompany oral health services provided in schools. These efforts seek to create a more embedded, sustainable oral health system within the school districts.

In the districts that are not yet participating, the School-Based Health Alliance is also working with the Hawaii Department of Education and Florida (which includes Miami-Dade and Broward County school districts) to develop state-wide school-based oral health models. Due to the ongoing implications of Hurricane Maria, Puerto Rico is unable to participate at this time.
The learning community helps share best practices and overcome challenges.

In addition to articulating a unified vision for school-based oral health, the School-Based Health Alliance learning community allows members to share their experiences and learn from each other. While each school district joined the learning community with their oral health models and sustainability policies formed to different extents, the learning community has helped members spread best practices and strategies for overcoming common barriers and accelerating work underway.

In 2017, the learning community convened to discuss a particularly widespread challenge: low parental consent rates for participation in school-based oral health programs. In response, members committed to testing innovative solutions in their districts, including direct family outreach in Los Angeles, community events in Houston, classroom education strategies in Chicago, and financial incentives in New York. They returned to the learning community to share what worked, highlighting their best practices in Confronting the Consent Conundrum, a white paper published in 2018. The School-Based Health Alliance also presented and facilitated activities around consent at the Connecticut Dental Sealant Advisory Workshop and the West Virginia Annual School Community Oral Health Conference. Together, the community tested and spread solutions to a common problem.

The School-Based Health Alliance also recently launched the School Oral Health Resource Library, an online index of resources for districts interested in learning more about strategies to strengthen oral health service delivery in schools.

The movement for school-based oral health is spreading to new school districts.

The ten largest school districts represent four million students, accounting for nearly 10 percent of all school-aged children in the United States. As these districts have become more involved in establishing school-based oral health programs, the momentum is spreading to others across the country. In the last two years, the School-Based Health Alliance has welcomed nine new school districts to its learning community from Arkansas, North Carolina, and South Carolina. In addition, Arkansas and Florida are working at the statewide level to support the expansion of school-based oral health. This growing interest in school-based oral health presents an opportunity for spreading the learning from the largest school districts to others around the country. Districts’ willingness to participate could allow the School-Based Health Alliance to scale its work to new school systems and reach more students.
Since 2014, nine states increased their adult dental benefits and achieved either a “limited” or “extensive” benefit package.

Having dental benefits is a key factor in an individual’s ability to access dental care in the United States. For low-income adults, however, Medicaid adult dental coverage varies widely across states – from no coverage, to coverage for emergency procedures only, to limited services, to comprehensive benefit programs.

Since January 2014, nine states have increased adult Medicaid dental benefits to such a degree that they successfully moved up to a “limited” or “extensive” benefit structure. Between August 2017 and July 2018, significant progress has also been made to improve available coverage. Two states, Idaho and Illinois, increased their benefit level. Three additional states, Connecticut, Maryland, and Massachusetts strengthened their oral health benefit packages by, for example, adding preventive dental care visits to the list of services covered by their state Medicaid programs. Three more states, Maine, Virginia, and Utah, expanded eligibility rules for Medicaid, enabling more low-income adults to participate.

Currently, 17 states and Washington, D.C. provide extensive dental benefits to all Medicaid recipients. Of the remaining states, 17 provide limited benefits, and 13 provide emergency benefits. Three states provide no benefits.

Despite progress, many states’ benefits have been threatened. Advocates in 17 states reported working to protect against various administrative changes that, if authorized by the federal government, would likely impede access to oral health care.
After years of advocacy, Idaho and Illinois successfully added new dental benefits for adult Medicaid recipients in 2018.

Idaho restored its Medicaid dental benefit, moving the state into the “Limited” adult dental benefit category. Following cuts to the benefit in 2011, advocates urged the Legislature and Governor to restore the dental benefit. As a result, Representative Kelley Packer filed House Bill 465 to accomplish this request; the bill passed both the House and Senate and was signed into law by Governor Butch Otter in March 2018.

Illinois funded dental prevention services for the first time, moving the state into the “Extensive” adult dental benefit category. Thanks to concerted advocacy efforts, Illinois Governor Bruce Rauner signed a 2019 state budget that provides adults in the state’s Medicaid program with dental prevention services for the first time. Moving forward, the Illinois Department of Healthcare and Family Services will be required to provide adult dental services — including preventive services and services needed to treat periodontal disease — to all adult Medicaid enrollees. Additionally, the Department of Healthcare and Family Services will be required to adopt new dental health metrics and publish them in its Medicaid Plan Report Card.

OPEN helps partners define success and coordinates efforts to strengthen Medicaid benefits across the country.

Since 2015, the DentaQuest Foundation, in collaboration with the American Dental Association’s Health Policy Institute, the Center for Health Care Strategies, National Academy for State Health Policy, and other oral health experts, have convened to develop the Rubric for Assessing the Extensiveness of Medicaid Adult Dental Benefits. In 2018, the Rubric was piloted with state Medicaid Dental Program Administrators. The purpose of the Rubric is to provide a definition for the field that moves beyond the number of procedures covered, to recognize specific procedures that are most likely to advance oral health.

In addition to better defining the elements of an extensive dental benefit, OPEN members are working to connect advocates across states to spread strategies and solutions for increasing dental benefit levels. In January 2018, Community Catalyst, the DentaQuest Foundation, and Families USA launched the Medicaid Adult Dental Benefit Learning Collaborative (MADBLC), a platform for advocates to share experiences and lessons learned from efforts to strengthen and protect the adult Medicaid oral health benefits in their states. By connecting people and organizations with a shared goal, the MADBLC helps accelerate the spread of new strategies and solutions to build upon national progress to enhance Medicaid adult dental benefits.
Medicare does not include an extensive dental benefit, but efforts to introduce a bill are underway.

Dental coverage is positively associated with access to and utilization of oral health care. Research indicates that adults with dental coverage are significantly more likely to seek and use regular dental services than their uninsured peers. Providing dental coverage and increased access to dental care positively impacts health and well-being. Since Medicare does not include a dental benefit, almost 70 percent of Americans age 65 and older do not have dental coverage.

With support from the DentaQuest Foundation, Oral Health America and the Center for Medicare Advocacy have worked together since 2015 to: (1) convene a broad group of stakeholders to advocate for medically necessary oral health care for seniors, (2) define a dental benefit model that fits within Medicare’s policy structure, (3) identify a core leadership team—including the American Dental Association, Families USA, Justice in Aging, and the Santa Fe Group—to champion future legislation with Congress, and (4) launch a media and advocacy campaign to increase support and awareness.

In 2017, Oral Health America launched the Demand Medicare Dental campaign, in which older adults in Florida mailed postcards and toothbrushes to their representatives. The pilot generated over 2,000 points-of-contact with Florida lawmakers, and created the foundation on which to build a national effort. In 2018, the Campaign is being replicated in three other strategic sites covering key congressional districts in Iowa, West Michigan, and East Tennessee.

Steps to authorizing a Medicare dental benefit:

- **Completed**
  - 2014. Convene a broad group of stakeholders
  - 2016-2018. Define the benefit
  - 2017-2018. Identify the core leadership team to champion the bill
  - 2017-2018. Launch media and advocacy campaign to increase support & awareness

- **Planned**
  - Find a legislative champion to introduce the bill to Congress
  - Analyze the cost of the benefit
With policy development research complete, a growing coalition is engaged in Congressional advocacy efforts.

In 2018, in collaboration with the core leadership team, Oral Health America published An Oral Health Benefit in Medicare Part B: It’s Time to Include Oral Health in Health Care which articulated details of an oral health dental benefit for the first time.

In articulating the oral health benefit structure—which includes preventive services such as cleanings, x-rays, screenings, and examinations—the white paper describes how the benefit could be integrated into the Medicare Part B structure, with the same cost-sharing components as other Part B components.

The white paper represents a milestone in the team’s efforts, setting the stage for the core leadership team to pivot beyond policy development and focus on Congressional advocacy efforts moving forward.

Medicare Oral Health advocates are working on multiple fronts to create a solution and build support.

Three workgroups have been established to move work toward this target forward. Updates from each workgroup include.

Policy and Procedure: The Policy and Procedure Workgroup led efforts to refine the proposed Oral Health benefit structure. Their work is in its final stages.

Marketing and Communications: This workgroup has supported research that shows that both consumers and oral health providers want to see oral health coverage added to Medicare.

Politics and Advocacy: With policy development and communication efforts underway, oral health Medicare leaders launched the Politics and Advocacy Workgroup in 2018. The workgroup has begun educating key Congressional offices on this issue and hosted a successful hearing in 2018 with the United States Senate Special Committee on Aging.
In 2018, key players outlined a policy agenda for achieving a comprehensive and coordinated measurement system.

Complete and consistent oral health data help advocates, policy makers, and researchers understand disparities, target resources and interventions, and measure progress over time. Since 2015, the Children’s Dental Health Project (CDHP), the Association of State and Territorial Dental Directors (ASTDD), and the DentaQuest Foundation have collaboratively led efforts to define oral health measurement priorities, a key step toward building a comprehensive measurement system.

This year, the group translated these priorities into policy recommendations. The resulting white paper, Making Oral Health Count, identifies opportunities for overcoming existing barriers and coordinating with federal and state efforts to improve the quality and accessibility of data, develop outcomes measures, and support health information technology for values-based care.

The team is now working with OPEN members to pursue the recommendations at the federal and state levels. At the regional convenings, they led learning circles to develop action plans for next steps and hosted conversations on the barriers that still exist across states. The group has also engaged with federal Health and Human Services Agency, the Centers for Disease Control and Prevention, and the Centers for Medicare and Medicaid Services to discuss policy opportunities to implement these priorities.
Stakeholder engagement has been critical to developing a coordinated measurement system.

In order to create a coordinated measurement system, federal and state entities of all types must cooperate to collect the same types of data throughout their programs. For this reason, the measurement team has engaged several key partners in their work: the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), the National Institute of Dental and Craniofacial Research (NIDCR), and the Centers for Medicare and Medicaid Services (CMS). In 2018, the group convened at the National Oral Health Conference in Louisville to discuss coordination between their agencies and steps that are being taken to incorporate measurement into new legislation.

In 2018, the measurement team successfully advocated to add select quality measurements to the bill reauthorizing the Children’s Health Insurance Program (CHIP). They are also working with Vermont senator Bernie Sanders to include measurement in health care bills in Congress. While the current political climate has made it challenging to make meaningful connections within the administration, the team is also re-engaging staff within Health and Human Services and the Centers for Disease Control and Prevention to open a constructive dialogue and craft meaningful recommendations for legislation.

In Florida, Critical Learning Systems, Inc. is scaling its online tool for defining oral health needs.

In 2017, Critical Learning Systems, Inc. (CLS) launched its national Oral Health Needs Index, an interactive online tool that defines the oral health needs of communities by linking existing data on the environmental and social determinants of health, health behaviors, and healthcare access data to oral health outcomes.

CLS is currently in the process of building out the website based on a pilot version launched in Florida. In the coming year, they will identify and engage national partners to help analyze, report, and utilize disaggregated national data, and seek partners to develop a financing model for data collection and analysis. Opportunities may exist to better integrate this work with that of OPEN, including communicating to members how the data can be used in their work.
The proportion of patients receiving oral health services at federally qualified health clinics is increasing in most regions.

Person-centered care encompasses a wide range of services and activities that aim to provide comprehensive care focused on the whole person. While new models continue to shift and emerge, federally qualified community health centers (FQHCs) are one lens through which to examine person-centered care. Following the passage of the Affordable Care Act in 2011, nearly two-thirds of FQHCs were designated or intended to become designated patient-centered medical homes. Furthermore, FQHCs are especially important for the most vulnerable and medically underserved populations, serving 24.3 million uninsured or underinsured people across 1,200 centers nationwide.

The wide reach of FQHCs and their importance to underserved populations make them a key area for integrating oral health into person-centered care. The National Network for Oral Health Access (NNOHA), a DentaQuest Foundation partner, has produced a set of seven metrics that FQHCs may implement to improve the quality of their oral health care.

While there is limited data on the integration of oral health into person-centered care models, a 2018 study published by the Oral Health Workforce Research Center shows that about one quarter of FQHC patients have received at least one oral health service at their FQHC, and that proportion is growing. The graph at right shows the growth in the proportion of patients who have received oral health services from 2011 to 2014 by region: the proportion grew by 9 percentage points in the Midwest and 5 percentage points in the Northeast, while service stayed steady in the West and decreased by 5 percentage points in the South. The number of patients receiving oral health care is also increasing overall as FQHCs grow, although not necessarily as a proportion of the total patients served.
Several states are testing ways to integrate oral health into patient-centered care models.

Medicaid is another important area in which oral health can be integrated into person-centered care. Members of OPEN have applied for the Medicaid Innovation Accelerator Program to test new approaches to incorporating children’s oral health delivery into person-centered care. In 2017, three states applied for and received support for this work.

In New Hampshire, the Department of Health and Human Services is working to increase the proportion of Medicaid enrolled children who receive preventive dental services. One strategy includes a pilot project offering preventive dental services for children and pregnant women at Women, Infants, and Children (WIC) offices.

In Michigan, the Department of Health and Human Services is working to increase the proportion of Medicaid enrolled children who receive preventive dental services. One strategy includes a pilot project offering preventive dental services for children and pregnant women at Women, Infants, and Children (WIC) offices.

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The District of Columbia is working to decrease caries experience and operating room treatment for high-risk children ages zero to six in Medicaid. Their grant helps create a perinatal “registry” to provide better care coordination between providers.

Interprofessional networks promote oral health integration.

Differences in beliefs and training, billing and information technology, referral processes, quality metrics, and other practices can make it difficult for medical and dental professionals to work together on person-centered care. To address these issues, the following efforts promote interprofessional integration across the United States:

The National Interprofessional Initiative on Oral Health (NIIOH) facilitates dialogue and develops and disseminates curricula—including the Smiles for Life curriculum—to integrate oral health into professional education programs for related health professions. As of Spring 2017, 18,000 individuals had completed Smiles for Life courses for Continuing Education Credit. A study released at that same time showed how the curriculum is influencing clinical practice, improving the frequency and quality of oral health activities and facilitating oral health inclusion in primary care.

National Oral Health Innovation and Integration Network (NOHIIN) is leading a national movement to unify and empower Primary Care Associations (PCAs) and safety net providers to be champions of oral health as an essential component of good overall health. NOHIIN serves as a learning collaborative of more than thirty primary care associations across the country.
Print media is talking about oral health more frequently. Many articles are about insurance, free services, and dentists.

In order to realize significant systems and policy changes, oral health must be communicated as essential to overall health. To spread this message, OPEN is engaging those most impacted by oral health disparities and the systems that negatively impact health outcomes. It is also monitoring changes in the frequency and nature of discourse around oral health.

Oral health is being discussed more frequently in print media sources. A review of 12 high circulation print media sources* found that between June 2017 and May 2018, oral health was discussed in 475 unique articles. A similar review of 15 high circulation print media sources** from 2015 found that between June 2014 and May 2015, oral health was discussed in 388 articles.

In the 2018 scan, 209 articles discussed insurance, 109 described free medical and dental services, and 82 were about dentists (e.g., profiles of individual dentists or laws and policies affecting dentists). Some 85 articles (18 percent) focused on oral health (i.e., the article’s primary purpose was to convey information about dental and/or oral health) and 384 (81 percent) mentioned oral health, but focused primarily on overall health or another topic.


**The 2015 print media scan included the sources listed above, as well as the Cleveland Plain Dealer, Phoenix Republic, Wall Street Journal

***Some articles were assessed to have more than one topic, so the total numbers of articles in greater than 475
OPEN members are using a common set of frames to guide oral health messaging.

In January 2018, the Frameworks Institute, with support from the DentaQuest Foundation, released *Reframing Oral Health: A Communications Toolkit for Advancing Oral Health Reform*. This multimedia resource builds upon the 2017 Message Memo, “Unlocking the Door to New Thinking: Frameworks for Advancing Oral Health Reform” and provides additional research and practical guidance about framing as a key strategy in achieving OPEN’s collective vision of accessible and equitable oral health.

The five *framing recommendations* included in the toolkit are:

- Connect oral health to overall health
- Use the value of Targeted Justice to cue a collective and systemic perspective
- Use the value of Responsible Management to broaden the concept of prevention
- Use the Keys to Oral Health metaphor to explain systemic barrier
- Emphasize that oral health involves a broad team of professionals

In March 2018, OPEN members convened to discuss how they could integrate framing recommendations and other resources from the toolkit into their work during the first Oral Health 2020 Public Perception Convening. The overall purpose of the convening was to build alignment on the goals, milestones, and tactics of the public perception goal and to build OPEN’s capacity to frame and develop effective messages that will reach multiple audiences and impact the public perception of oral health.

Grassroots Grantees are promoting oral health in health dialogue and public policy by engaging communities in bottom-up, collective action.

In July 2018, Grassroots grantees met in Pennsylvania for the annual Grassroots Summit to deepen connections and build power among OPEN grassroots activists and to accelerate their learning in collaboration, health equity, and advocacy to further their collective impact. During the Summit, the group discussed how to become, identify, and connect to trusted messengers in their communities. By doing this grassroots advocates can more effectively elevate the value of oral health and continue to mobilize their communities to advocate for their oral health needs. They also participated in training from Frameworks Institute on how to employ resources from the Reframing Oral Health Toolkit and shared their collective definition for Grassroots as a movement, a framework, and an approach in the context of Oral Health 2020 to guide their efforts mobilizing and engaging communities. The definition is below.

**Grassroots Definition**

The **PEOPLE** most impacted by the problems and conditions we are trying to solve. It’s a **MOVEMENT** with a **BOTTOM-UP** decisions-making approach that uses **COLLECTIVE ACTION** from the local level to effect change at the local, regional, and national level.

Grassroots organizations are the **VEHICLES** that leverage the resources, skills, and tools **PEOPLE** need to identify priorities, identify **COMMUNITY-BASED SOLUTIONS**, and to become their own advocates in an effort to challenge traditional power structures.

*Capitalized and bold words were determined by the definition’s authors*


8. Data provided by Eileen Espejo, Children Now, August 2018.


12. Data provided by Stacey Auger on behalf of the DentaQuest Foundation
ENDNOTES

13. Data provided by Stacey Auger on behalf of the DentaQuest Foundation
14. Data provided by Stacey Auger on behalf of the DentaQuest Foundation
15. Data provided by Stacey Auger on behalf of the DentaQuest Foundation
18. Data provided by Bianca Rogers, Oral Health America.