Oral Health Policy Development Since the Surgeon General's Report on Oral Health

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This assessment of the nature and impact of oral health policy development since issuance of the Surgeon General's Report on Oral Health (SGROH) in 2000 includes the following: an examination of the intent and content of the SGROH with respect to policy development; a general overview of ensuing oral health policy development in 3 principal domains: public policy, organizational policies, and professional policies; an assessment of indicators of the aggregate impact of oral health policy development after the SGROH and possible reasons for the somewhat limited progress; and a summary that includes conclusions and recommendations for advancing future oral health policy development. Evidence suggests that accomplishments in the area of oral health policy development have been modest but positive, but a significant amount of work remains to be done to address oral health disparities. Success is likely to be proportionate to the extent to which factors that have impeded substantial progress to date, including fragmentation of efforts and disparate priorities, can be effectively addressed.

KEY WORDS: children; oral health; policy; Surgeon General

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This necessarily broad yet limited assessment of the nature and impact of oral health policy development since the Surgeon General's Report on Oral Health (SGROH) was issued in 2000 begins with an examination of the intent and content of the SGROH with respect to policy development. Subsequent sections include a general overview of ensuing oral health policy development in 3 principal domains: public policy, organizational policies, and professional policies. Attention is then directed toward an assessment of indicators of the aggregate impact of oral health policy development after the SGROH and possible reasons for the somewhat limited progress, followed by a summary that includes conclusions and recommendations for advancing future oral health policy development.

REFERENCES TO ORAL HEALTH POLICY DEVELOPMENT WITHIN THE SGROH

Implicit in the charge of examining oral health policy development after the issuance of the SGROH is the notion that the report was intended to stimulate substantial policy development. The preface of the SGROH[1] explicitly affirms that intention, at least with respect to health promotion and disease prevention, as evidenced by the following statement: "The report should also serve to strengthen the translation of proven health promotion and disease prevention approaches into policy development, health care practice, and personal lifestyle behaviors."

The SGROH preface also notes, "A framework for action that integrates oral health into overall health is critical if we are to see further gains." The policy-related aspects of this framework for action called for "the development of a National Oral Health Plan to improve quality of life and eliminate health disparities by facilitating collaborations among individuals, health care providers, communities, and policymakers at all levels of society and by taking advantage of existing initiatives."

Beyond the call for creation of this structural element to guide policy development (ie, a National Oral Health Plan), the apparent scope and intended principal action strategy for achieving policy reform seems to have revolved around changing policy makers' perceptions about oral health, as revealed by the following statement. "Informed policymakers at the local, state, and federal levels are critical in ensuring the inclusion of oral health services in health promotion and disease prevention programs, care delivery systems, and reimbursement schedules. Raising awareness of oral health among legislators and public officials at all levels of government is essential to creating effective public policy to improve America's oral health. Every conceivable avenue should be used to inform policymakers—informally through their organizations and affiliations and formally through their governmental offices—if rational oral health policy is to be formulated and effective programs implemented."[1]

On the basis of the above statements, it seems reasonable to conclude that those responsible for producing the SGROH foresaw the value and potential role of the report in fostering oral health policy development—primarily as a tool for informing policy makers of the importance of oral health to overall health and documenting the extent of disparities within the US population. Delineation of specific oral health policy priorities and strategies for achieving significant policy development to address

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profound disparities were not included in the SGROH; instead, they were relegated to others via a call for development of a National Oral Health Plan. The rudiments of such a plan were formulated as part of the subsequent activities of a group of stakeholders convened by the Office of the Surgeon General's National Call to Action to Promote Oral Health.[2] However, the question of how to extend the group's recommendations to policy development was left largely unanswered.

OVERVIEW OF POST-SGROH ORAL HEALTH POLICY DEVELOPMENT

This overview of post-SGROH oral health policy development is organized according to 3 policy domains: public policy, organizational policies, and professional policies. A partial listing of activities deemed to represent prominent examples of policy development is included within each section.

Public Policy

Responsibility for public policy development primarily rests with the legislative and executive branches of federal and state governments. When necessary, the judicial branches of federal and state governments are called on for interpretation, enforcement, and implementation of public policy.

US Congress

Although congressional activity related to oral health policy development predated the SGROH, it seems reasonable to conclude that issuance of the SGROH helped to stimulate the introduction of a number of oral health–related bills in the US Congress over the next 9 years. Although none of these bills has moved to the stage of being voted on as such, various provisions—generally those dealing with safety-net, workforce, and dental benefits in children's health insurance program issues—have been incorporated into other bills that have been enacted. Prominent examples of proposed legislation focused exclusively on oral health include multiple versions of the Children's Dental Health Improvement Act;[3] the Collins-Feingold Dental Health Improvement Act, which was later included in the Health Care Safety Net Amendments of 2002;[4] the Special Care Dentistry Act of 2005,[5] which focused on the needs of the blind, aged, and disabled; and a section of the reauthorization of the Children's Health Insurance Program (CHIP) legislation[6] signed into law by President Obama in 2009.

The death of Deamonte Driver in Maryland[7] in 2007 touched off a flurry of congressional action, including the introduction of numerous bills related to children's oral health and a series of hearings focused on the adequacy of Medicaid program oversight provided by the Centers for Medicare and Medicaid Services (CMS). One outcome of these hearings was a 2008 National Dental Summary[8] issued by CMS detailing the findings of reviews of 15 State Medicaid programs where less than 30% of children enrolled in Medicaid received any dental services within a 12-month period and state-specific recommendations for improving Medicaid Early Periodic Screening, Diagnostic, and Treatment (EPSDT) program performance. The congressional General Accountability Office also has been involved in several investigations of the performance of state dental Medicaid programs.[9]

Arguably, the most notable product of post-SGROH congressional efforts to effect changes in oral health–related public policy to date has been the changes made to federal legislation concerning CHIP dental benefits. Specifically, the 2009 CHIP reauthorization:

- Requires the child health assistance provided to a targeted low-income child to include coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.
- Gives states with a separate CHIP program the option to provide dental-only supplemental coverage for any child enrolled in a group health plan or employer-offered health insurance coverage who would otherwise satisfy the requirements for a targeted low-income child under a state child health plan.
- Allows a state child health plan, at state option, to waive a waiting period for a child provided dental-only supplemental coverage.
- Requires the Secretary to develop, through entities that fund or provide prenatal care services to targeted low-income children under CHIP, a program to deliver oral health educational materials that inform new parents about risks for, and prevention of, early childhood caries and the need for a dental visit within their newborn's first year of life.
- Directs the Secretary to work with states, pediatric dentists, and other dental providers to include on the Insure Kids Now Web site (http://www.insurekidsnow.gov) and hotline (1-877-KIDS-NOW) a current and accurate list, updated quarterly, of all dentists and providers within each state who provide dental services to children enrolled in the state plan (or waiver) under Medicaid or CHIP, together with a description of the services.
- Directs the Comptroller General to study and report to Congress on children's access to dental services in underserved areas and to oral health care.[6]

Despite the many positive elements of recent federal legislative activities related to oral health, federal initiatives to date have stopped short of requiring dental benefits for all children covered by publicly financed programs. And despite surveys showing that over 60% of US adults think that dental coverage is an important part of health care reform,[10] implementation of that attitude by means of federal legislation is far from certain. Thus, on the basis of actions taken before this article was submitted, it seems reasonable to characterize the impact of post-SGROH congressional activities as positive but modest, and largely confined to actions taken since 2007.

Federal Agencies

Notable oral health–related public policy activities by federal agencies since issuance of the SGROH include

requirements by the Health Resources and Services Administration that new construction or expansions of federally funded health centers to have dental clinics,[6] CMS's release of a *Guide to Children's Dental Care in Medicaid,*[11] activation of a CMS Oral Health Technical Advisory Group, and the multiagency-sponsorship of a demonstration program to train North Carolina primary medical care providers to conduct oral health assessments, counseling, preventive procedures, and referrals. The Centers for Disease Control and Prevention also provided support to the Association of State and Territorial Dental Directors to establish a National Oral Health Surveillance System that includes key children's dental health indicators that can be used to monitor progress and guide state policy development; to date, 37 states have participated.[12]

Outside the Department of Health and Human Services, the Department of Defense expanded coverage for anesthesia services when necessary for oral rehabilitation of eligible child dependents of military personnel.[13] On the other hand, other federal agency policy actions—primarily related to new or proposed CMS regulations during the Bush administration—presented considerable challenges to the funding of dental residency training programs and previous dental Medicaid program improvement efforts,[14] although the impact of the proposed changes was diminished as a result of a moratorium on their implementation (A. Conan Davis, Centers for Medicare and Medicaid Services, September 8, 2009, personal communication).

State Legislatures

Prominent oral health public policy development activities by state legislatures since the issuance of the SGROH have been summarized by the National Conference of State Legislatures.[15] Cited activities include efforts to improve dental Medicaid programs (primarily for children), requiring oral health assessments for school-age children, reimbursing nondental providers (physicians) for oral health services, and a host of workforce-related developments, largely related to dental hygienists and other types of midlevel providers. Policy changes related to workforce issues generally have involved increasing the scope of practice for various oral health professionals (primarily dental hygienists), loosening requirements for supervision of dental hygienists in community or public health settings, providing incentives (eg, loan forgiveness or loan repayment programs) for dentists to practice in underserved areas, and addressing access to care issues for rural and frontier populations. There also has been continued legislative activity requiring water fluoridation for municipal water supplies in a number of states.

State Agencies

Perhaps the most notable oral health–related policy activities of state agencies are those involving financing and administration of dental Medicaid or State Children's Health Insurance Program (SCHIP) programs. On the positive side, several states have taken significant steps to address long-standing problems related to an insufficient number of dentists willing to treat Medicaid-enrolled children by increasing reimbursement rates, streamlining administrative procedures, and expanding outreach programs designed to provide education and case management for Medicaid beneficiaries. A trend toward carving out the administration and management of dental Medicaid programs from global Medicaid managed care programs also has been noted.

The CMS Web site's section on Medicaid and SCHIP Promising Practices[16] provides an overview of improvements in Medicaid children's access to care in South Carolina, Tennessee, and Virginia after program reforms. Michigan's Healthy Kids Dental Program is also often recognized for achieving significant increases in dentists' participation in Medicaid and improvements in access to care for Medicaid children.[17] A small number of states also have developed dental periodicity schedules for their Medicaid EPSDT programs in an effort to clarify the types of services that should be provided for children at recommended intervals. The general status of adult dental Medicaid programs has deteriorated since issuance of the SGROH, with many states scaling back the scope of benefits available to adults or eliminating optional Medicaid dental benefits for adults entirely.[18] This leaves caregivers without coverage for dental services that would not only enhance their own well-being, but also promote the development of healthy personal habits and use of professional dental care among families. One positive development with respect to adult Medicaid programs relates to the inclusion of Medicaid dental benefits for pregnant women in some states; however, state budget challenges may diminish the impact of this activity in the near term.

Federal Courts

In spite of the positive activities noted above, there remains a considerable level of oral health activity in the federal courts, primarily involving litigation challenging the adequacy of state dental Medicaid programs' provision of equal access to dental services for children covered by Medicaid.[19,20] These cases generally involve protracted litigation, but usually result in judgments or settlements that seek to remedy inadequate reimbursement and other widely recognized barriers to dentists' participation in Medicaid. Recent examples include cases that were successfully litigated in Connecticut and Texas.

Organizational Policies

Organizational or program policies generally relate to public or private program administration or operational issues. Organizational policy issues may include the design and operation of dental benefits programs, or rules or guidelines governing the operation of oral health programs such as school-based sealant programs or oral health provisions of broader programs such as Head Start or state Title V programs for children with special health care needs. The recent Revised Oral Health Program Instruction issued by the Office of Head Start is an example of a formal organizational policy development that seeks to direct oral

health–related activities within local Head Start programs.[21] More broadly, changes in the design of dental benefit programs appear to be largely driven by market forces. Dental benefits remain a highly sought after employee benefit, ranking third after health and retirement benefits.[22] General cost increases in employee benefits are impacting employer-sponsored coverage such that the prevalence of employer-based dental coverage has remained relatively constant; however, the costs of the benefits are increasingly being shifted to employees.[23]

Professional Policies

There has been considerable activity in the realm of oral health–related professional policy development since the issuance of the SGROH. Prominent examples include:

- Adoption by various dental and medical organizations including the American Academy of Pediatric Dentistry, American Academy of Pediatrics, and American Dental Association of policies related to the concept of a dental home, and early initiation of regular dental visits for infants and children.[24,25]
- Clinical guidelines for risk-based dental caries prevention.[26,27]
- Guidelines for oral health care during pregnancy.[28]
- The Maternal and Child Health Bureau–sponsored revision of the Bright Futures Guidelines for Health Supervision for Infants, Children, and Adolescents.[29]

The major source of professional policies related to children's oral health and the clinical aspects of oral health care are the policies and guidelines published annually by the American Academy of Pediatric Dentistry (AAPD).[30] However other professional organizations outside of dentistry, most notably the American Academy of Pediatrics and the American Academy of Family Physicians, have undertaken strategic organizational activities and policy developments that support the dental home concept, emphasize the importance of oral health, and encourage primary care physicians to incorporate oral health–related services (eg, oral health assessments, anticipatory guidance, preventive services, referrals to dental homes) into their practices, particularly for young children.

The dental home concept is derived from and closely parallels the medical home concept. The AAPD defines a dental home as an "ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way."[31] Establishment of a dental home by age 1 has been adopted as professional policy by numerous dental, medical, and public health organizations since publication of the SGROH. According to AAPD, a dental home should provide:

- Comprehensive oral health care including acute care and preventive services in accordance with AAPD periodicity schedules.
- Comprehensive assessment for oral diseases and conditions.
- Individualized preventive dental health program based on a caries risk assessment and a periodontal disease risk assessment.
- Anticipatory guidance about growth and development issues (ie, teething, digit or pacifier habits).
- Plan for acute dental trauma.
- Information about proper care of the child's teeth and gingivae (including the prevention, diagnosis, and treatment of disease of the supporting and surrounding tissues and the maintenance of health, function, and aesthetics of those structures and tissues).
- Dietary counseling.
- Referrals to dental specialists when care cannot directly be provided within the dental home.
- Education regarding future referral to a dentist knowledgeable and comfortable with adult oral health issues for continuing oral health care.[24]

Relatively little activity has occurred on the development and application of quality metrics related to pediatric oral health care since publication of the SGROH. However, provisions in the recent CHIP legislation reauthorization include support for the development of children's health care quality measures for Medicaid and CHIP, and dental measures are being considered as part of this work. The American Dental Association also has recently initiated a Dental Quality Alliance that will develop programmatic performance measures to assess oral health care quality for Medicaid patients, with representation from the AAPD.[32]

INDICATORS OF THE IMPACT OF ORAL HEALTH POLICY DEVELOPMENTS

Ultimate measures of the impact of oral health policy development include changes in the oral health status of the population or subsets thereof or changes in the quantity or quality of services provided for relevant groups of interest. Data on these ultimate measures are often difficult or costly to obtain, necessitating the use of data representing indicators or indirect proxies for status or provision of services. An example of such an indicator is the data included in dental services component of the annual CMS-416 reports.[33] Data reported in the CMS-416 indicate that the percentage of US children enrolled in Medicaid who access dental services has risen from fewer than 2 in 10 in the early 1990s to roughly 3 in 10 in fiscal year 2005. These data provide a crude indication of the impact of aggregate changes in Medicaid programs but fall short of providing definitive information on the oral health status or levels of unmet treatment needs in Medicaid-eligible children. Likewise, data on dental services provided in community health centers (CHCs)—which have significantly increased their capacity for providing dental services as a result of federal policy emphasis since publication of the SGROH—indicate that the number of CHCs providing dental services increased from 450 (of 731) in 2000 to 678 (of 952) in 2005, and that over 5 562 000 dental visits were provided to over 2 340 000 patients in CHCs in 2005 compared with 3 000 000 dental visits and 1 300 000 patients in 2000.[34] However, these figures include services provided to adults—who generally constitute the majority of CHC patients—as well as children. Although the increases are substantial, the services provided in CHCs

represent approximately 1% to 2% of all dental visits in the United States.

The SGROH contained relatively few data on SCHIP programs because those programs were just beginning to be implemented when the SGROH was developed. However, information from Medical Expenditure Panel Survey has documented several findings related to dental coverage and use of dental services after enactment of SCHIP legislation. For example, the percentage of children with public dental coverage (only) increased and the percentage of children with no dental coverage decreased between 1996 and 2004. Children with public dental coverage (only) experienced an increase in the likelihood of a dental visit between 1996 to 2004, as did younger children, low-income children, black non-Hispanic children, and Hispanic children.[35]

The Healthy People 2010 oral health objectives represent another set of indicators of the impact of oral health policy developments. A February 2008 progress report by staff of the National Center for Health Statistics[36] indicated that despite increases in insurance coverage, nearly 3 times as many children lacked dental insurance as lacked medical insurance in both 1995 and 2003–2004. Of the oral health objectives and subobjectives that were continued after the Midcourse Review of Healthy People 2010,[37] 2 have met or exceeded their targets, 6 are improving, 1 moved away from the target, 11 have shown little or no progress, and 6 are without data for measuring progress. Assessment of these findings and related data reveals that for 12 of the 18 Healthy People 2010 oral health objectives for which data are available, progress toward improvements in the overall oral health of the public has plateaued since issuance of the SGROH. Table 3 of the paper authored by Drs Tomar and Reeves[38] in this issue provides a summary of progress on the Healthy People 2010 measures related to children's dental health. Moreover, the data suggest that substantial oral health disparities persist for economically disadvantaged and racial/ethnic minority groups. Clearly, greater attention needs to be directed toward oral health policy development and implementation to address this situation.

FACTORS UNDERLYING LIMITED FUNDAMENTAL PROGRESS IN ORAL HEALTH POLICY DEVELOPMENT

In examining possible reasons for the limited progress that has been achieved in the area of oral health policy development since issuance of the SGROH, many point to various extrinsic/contextual or inherent factors. Examples of extrinsic or contextual factors include events such as the 9/11 terrorist attack and the Iraq war, changes in US and state economies, and the resultant consequences for federal and state budgets, and competing health policy priorities such as mental illness, obesity, or an expanding senior population. Others counter that policy development inherently takes considerable time or suggest that reforming oral health policy is particularly difficult given that oral health problems are disproportionately concentrated in groups with limited political leverage. Other inherent factors include the tendency to blame those with poor oral health for not taking appropriate steps to achieve good oral health, and the long-standing failure to include oral health in most publicly funded health programs. Although each of these perspectives is likely to have some salience, observing the progress made in the area of mental health policy development over the same time since the Surgeon General's Report on Mental Health was issued suggests that significant progress may well be possible even under trying external circumstances.[39]

The various factors noted above undoubtedly have accounted for some of the difficulty in achieving fundamental oral health policy reform since the SGROH was issued. However, part of the explanation for the limited policy achievements also must relate to gaps in leadership and the failure to unite a critical mass of key stakeholders with sufficient common interests, political will, and resources to effect fundamental policy change, starting with the public policy arena. Absent those essential elements, oral health policy development is likely to continue to be fragmented and limited in terms of its impact.

CONCLUSIONS AND RECOMMENDATIONS FOR FUTURE EFFORTS

The first-of-its-kind Surgeon General's Report on Oral Health provided a foundation of knowledge that highlighted the extent of a silent epidemic of oral health problems, the magnitude of disparities within the US population, and the scientific evidence for approaches for improving oral health. Its expressed intent was to raise policy makers' awareness of these findings—a goal that most certainly has been achieved in many venues. As with many similar efforts, this initial stimulus has not proven to be sufficient to achieve profound changes in public policy. Nevertheless, one can point to a considerable activity and some significant achievements in various policy arenas that undoubtedly were fueled by the information and importance conveyed by the SGROH. As we pause to speculate on the impact of the SGROH and reflect on the extent and significance of oral health policy development in the ensuing years, there most certainly is reason for both a sense of accomplishment and an appreciation for the amount of work yet to be done.

Available data suggest that profound disparities and significant oral health problems persist in growing segments of the US population. Finding ways to effect policy changes that will extend proven methods for achieving oral health to the entire population in the most efficient manner is the fundamental challenge facing those concerned with oral health policy.

The original premise of the SGROH—that policy makers must be convinced that oral health is an essential and integral element of overall health, and that oral health care is an essential and integral element of health care—remains valid. However, merely raising policy makers' awareness of this tenet is not sufficient to achieve

successful policy formulation and implementation. Achieving that goal will require levels of collaboration, innovation, leadership, and determination beyond those that have been demonstrated heretofore. Key considerations for successful policy development include:

- Responding to the fundamental tenet of the SGROH that oral health is integral to health and oral health services are an essential component of health care by ensuring that dental benefits—and in particular those services that can legitimately be considered to be medically necessary—are considered essential or mandatory components in any future legislation or policies concerning health care for US children.
- Ensuring that adequate funding is provided for children's dental benefits provided through public programs (eg, through Medicaid, CHIP, or Title V programs).
- Ensuring adequate attention to accountability, quality, and performance in public dental benefits programs, which also will require support of further development and implementation of quality/performance measures for children's dental services.
- Making a concerted effort to meet oral health–related targets such as those set out in Healthy People 2010 objectives and redoubling efforts to eliminate existing disparities in health oral health status and provision of essential oral health services.

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