

Applying Research and Policy to Improve Pediatric Oral Health

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Integrating Oral Health into the Pediatric Medical Home

Friday, December 11, 2009

Freeport, ME

My topics for this morning...

- Why children's oral health ?
- Why the “medical home” ?
- Interplay among science, policy and the oral health of children

An overarching vision...

“To develop a standard of well-child care that includes oral health for all children.”

Washington Dental Service
and the WDS Foundation

An overarching vision...

“Promote policies that will help millions of children maintain healthy teeth, and come to school ready to learn.”

Pew Children’s Dental Campaign

Some resources...

- Children's Dental Health Project
(www.cdhp.org)
- National Academy for State Health Policy
(www.nashp.org)
- Pew Children's Dental Campaign
(www.PewCenterontheStates.org/dental)
- Amer. Acad. Pediatric Dentistry (www.aapd.org)
- Special Issue on Children's Oral Health -
Academic Pediatrics, Vol. 9; Issue 6 (Nov., 2009)
(www.academicpedsjnl.net/)

Some resources...

- Amer. Acad. of Family Physicians (www.aafp.org)
 - STFM Group on Oral Health - Since 2006, oral health education has been required component of family medicine residency training
 - Smiles for Life curriculum - <http://www.smilesforlife2.org/>
An oral health curriculum of the Society of Teachers of Family Medicine Group on Oral Health and endorsed by the AAFP
- Amer. Academy of Pediatrics (www.aap.org)
 - Section on Pediatric Dentistry and Oral Health (SOPDOH).
 - AAP Oral Health Initiative
 - www.aap.org/healthtopics/oralhealth.cfm

Disclosures

- Dentist - *orocentric* view of universe
- Scientist
- Advocate
- Board member
 - Health Care For All, Inc.
 - DSM, Inc.
 - ADA Foundation

From Problems to Solutions...

2001 – Meskin editorial in JADA

“Look who’s practicing dentistry”

“Why this medical intrusion into an area where dentistry has been the undeniable leader—the promotion of preventive dentistry for children?

It’s the need to ensure access to dental services, or the lack of that access, that is the stimulus.”

From Problems to Solutions...

2001 – Meskin editorial in JADA

“Look who’s practicing dentistry”

“A study of unmet health needs of children found those requiring dental care topped the list with 5.3 percent (3.4 million); the percentage with unmet medical needs was only 1.6 percent.”

(data from Pediatrics, 2000;104:989-996.)

MESKIN, L JADA 2001;132(10): 1352.

From Problems to Solutions...

2001 – Meskin editorial in JADA

“Look who’s practicing dentistry”

“Encouragement for these medically supplied dental services arose from public concerns regarding inadequate access to dental services. In 1998, only 12 percent of [North Carolina’s] Medicaid-enrolled children aged 1 year to 5 years visited a dentist.”

From Problems to Solutions...

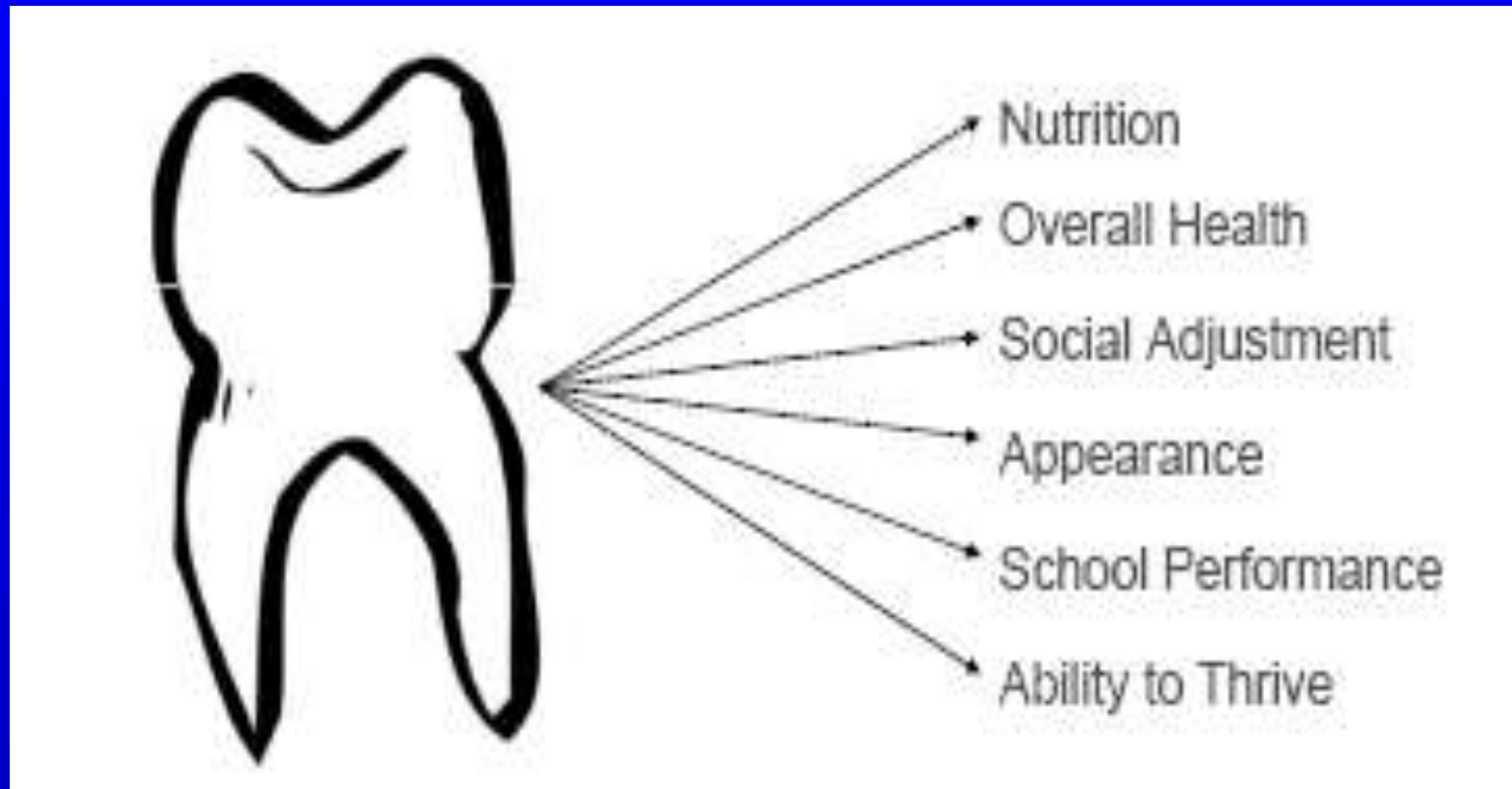
The ADA and health care reform.

JP Crowley, Chair, ADA Council on Government Affairs. JADA, October 2009

“Fundamentally, our advocacy is guided by ADA policy based on a belief that the **dental delivery system** works extremely well for most Americans and **should be left untouched by any reform effort.**”

Why does oral health matter?

Poor oral health can affect a child's...





Northeast Center for Research to Evaluate
and Eliminate Dental Disparities
(*The CREEDD*)

www.bu.edu/creedd

Supported by the National Institute of Dental and
Craniofacial Research, NIH (U54 DE019275)

Disparities Exist

“Despite improvements in oral health status, **profound disparities remain** in some population groups as classified by sex, income, age, and race/ethnicity. For some diseases and conditions, the **magnitude of the differences in oral health status among groups is striking.**”

Oral Health in America: A Report of the Surgeon General. Rockville, MD: USDHHS, NIDCR, NIH, 2000



Center 'Themes'

Connect the mouth to the body

Translate scientific evidence into
policy and practice

Eliminate oral health disparities



Center 'Themes'

Oral health promotion and disease prevention

- In “non-dental care” settings
 - The ‘well-child’ medical care visit, in CHC
 - Public housing developments
- Delivered by “non-dental care” providers
 - Medical care providers (MD/NP/RN/PA)
 - Public housing residents - “*regular folks*”

ORAL HEALTH AND THE COMMONWEALTH'S MOST VULNERABLE CHILDREN: A STATE OF DECAY



2008 Massachusetts Oral Health Report

Mass. Oral Health Advocacy
Task Force

Release of State Oral Health
Report at State House
Legislative Briefing
January 2008:

**SIGNIFICANT DISPARITIES IN
ORAL HEALTH OF CHILDREN
IN MASSACHUSETTS**



**The Oral Health of
Massachusetts' Children**

January 2008

“CAVITIES” – Dental Caries



“CAVITIES” – Dental Caries

- Pain
- Eating difficulties
- Sleep disturbance
- Impair growth and development
- Interfere with learning



Maryland boy dies from toothache

Maryland boy, 12, dies after bacteria from tooth spread to his brain

By Mary Otto **The Washington Post**

Updated: 12:11 p.m. ET Feb 28, 2007

WASHINGTON - Twelve-year-old Deamonte Driver **died of a toothache** Sunday. A routine, \$80 tooth extraction might have saved him. If his mother had been insured. If his family had not lost its Medicaid. ...

Early Childhood Caries



Photos courtesy of Drs. J Douglass and MW Ng

Early Childhood Caries

- **NHANES III - children with ECC**

1.0% 12-23 month olds

4.7% 24-35 months

7.7% 36-47 months

8.7% 48-59 months

11.6% 60-71 months

Early Childhood Caries

NHANES III: Disparities in ECC (12 – 23 mo.)

0.8% Non-Hispanic Whites

1.1% African Americans

3.6% Mexican Americans

Early Childhood Caries

- NHANES III: Disparities in ECC (4 to <5 y.o.)
 - 5.4%** Non-Hispanic Whites
 - 9.0%** African Americans
 - 17.9%** Mexican Americans

‘Uneven Distribution’ of Oral Disease – Disproportionately Affecting the Poor and Racial/Ethnic Minorities

~25% of children and adolescents account for **~80%** of dental caries

Findings from the 2003 National Survey of Children's Health

Significantly more Hispanic parents reported that their children:

- “did not receive all preventive care needed in past year”
- had “no dental visits within past 12 months”
- had “never been to a dentist”
- had “fair or poor oral health”

Fair or poor oral health rating on the 2003 NSCH

| Non-Hisp. Whites (n=59,040) | Non-Hisp. Blacks (n=8,214) | Hispanics (n=10,479) |
|--------------------------------|-------------------------------|-------------------------|
| 6.5% (6.1 - 6.8) | 12.0% (10.9 - 13.3) | 23.4% (21.9 - 25.1) |

Racial/Ethnic Disparities in Oral Health Status and Access to Care

Controlling for age, gender, and SES reduces many of the disparities, but significant racial/ethnic disparities still remain, with Latinos usually worse off.

Multivariate odds ratio for association between race/ethnicity and fair or poor oral health rating on the 2003 NSCH

| Non-Hisp. Whites (n=59,040) | Non-Hisp. Blacks (n=8,214) | Hispanics (n=10,479) |
|--------------------------------|-------------------------------|-------------------------|
| 1.0 | 1.2 (1.1 – 1.4) | 2.1 (1.9 – 2.4) |

Adjusted for age, sex, education, poverty level and dental insurance.

Racial/Ethnic Disparities in Access to Dental Services

- Overall: Only 25% of Hispanics had a dental visit in past year, while over 46% of Whites had dental visit in past year Source: DHHS/MEPS
- **Poor Children:** Only 16% of poor Hispanic children and 13% of poor Black children obtained preventive care in a year compared with 25% of poor white children Source: DHHS/HP2010

Using Research Data: Coverage, Care, Disease, Consequences

- 2-3 times more children lack dental insurance than medical insurance coverage
- Young children with coverage are twice as likely to obtain care compared to uninsured children.
- Caries, though preventable is most common chronic disease of children affecting 44% of 5 y.o.
- Oral health is consequential: young low-income children are twice as likely to have pain.

The 'medical home' for dental care

North Carolina – *Into the Mouths of Babes*

Prevention program for children under age three developed out of a local recognition that infants and toddlers received care in the medical office far earlier and far more often than in the dental office. This insight has developed into a multi-pronged effort to train physicians to identify the signs of oral disease, provide oral health education and preventive services like fluoride varnish, and provide appropriate referrals of children with treatment needs to dentists.

“Increasing Access to Dental Care in Medicaid: Targeted Programs for Four Populations.” NASHP, March 2009.

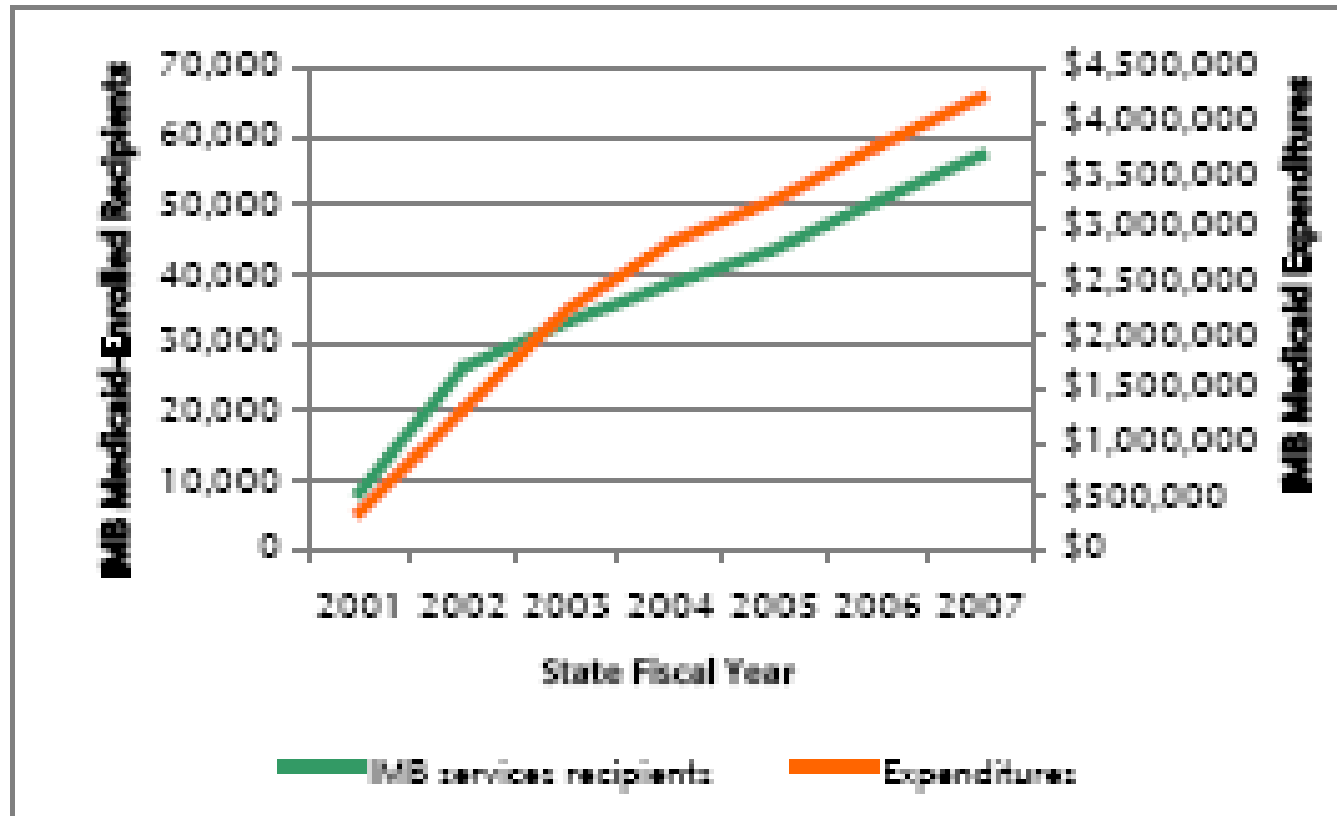
www.nashp.org/Files/dentalreimbursements.pdf

North Carolina – *Into the Mouths of Babes*

The program moved from a pilot in the state's Appalachian region to a statewide initiative with the introduction of Medicaid reimbursement. Medicaid pays \$54 per visit for up to six visits, up to age three and a half.

North Carolina – *Into the Mouths of Babes*

Chart 1. Into the Mouths of Babes Spending and Utilization, 2001-2007



Source: Testimony of Dr. Mark Casey, North Carolina Department of Health and Human Services, Division of Medical Assistance, to House of Representatives Domestic Policy Subcommittee, September 23, 2008.

Washington State

Washington Dental Service and WDS Foundation

“Delivering Preventive Oral Health
Services in Pediatric Primary Care:
A Case Study”

Ritter et al., *Health Affairs* 2008; 27(6):1728-1732.

Washington State

Washington Dental Service and WDS Foundation

- 1998 – the Washington State Medicaid Program became first in nation to reimburse PCPs for fluoride varnish applications
- 2008 – reimbursement was extended to include oral screenings and oral health education
- Funding for Primary Care Medical professionals to deliver oral health services during well-child checks
- Since 2001, WDS Foundation has trained over 2,200PCPs and their staff

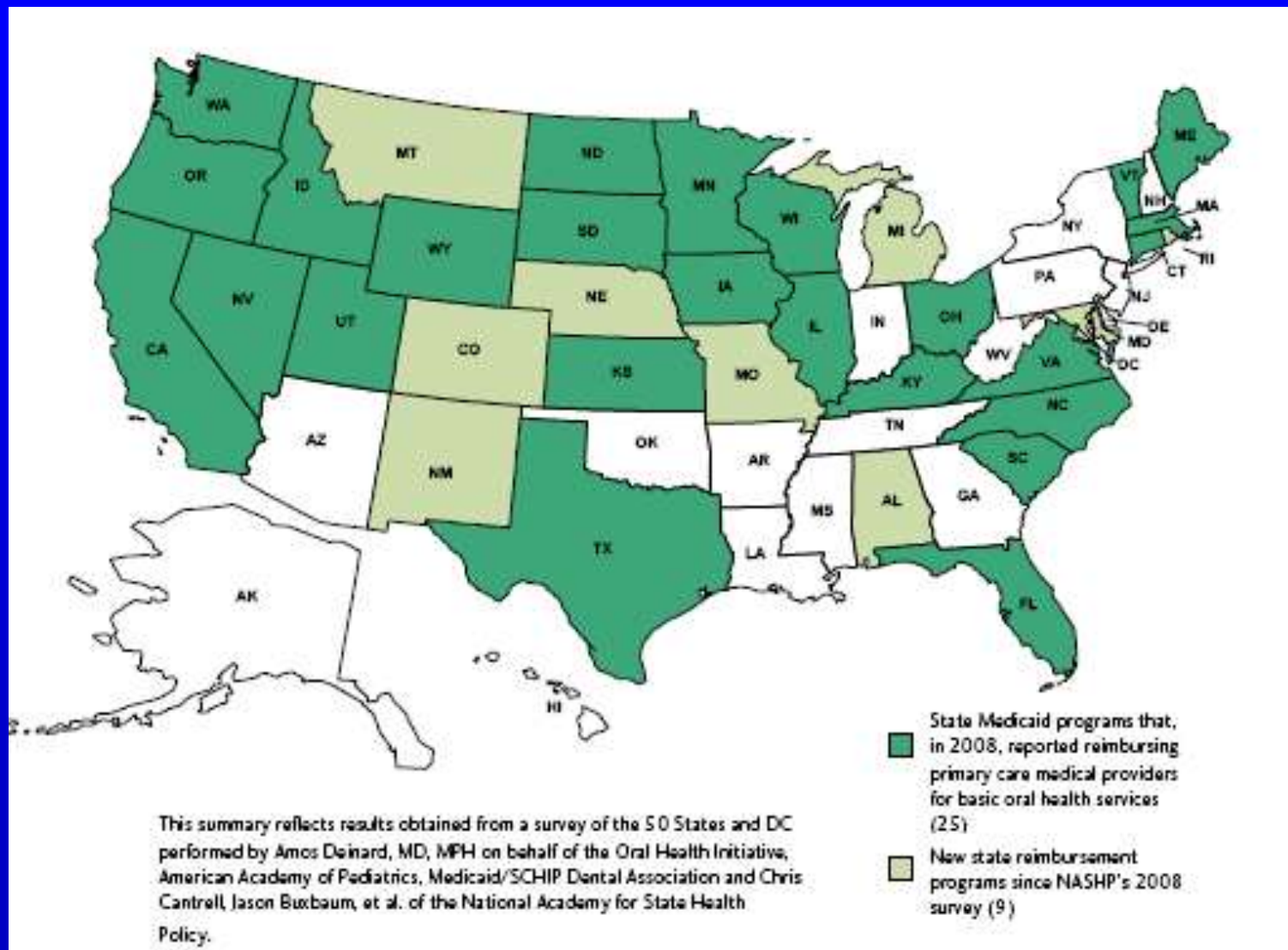
Washington State

Washington Dental Service and WDS Foundation

In January 2001, the Washington Dental Service Foundation funded the **Citizens' Watch for Oral Health Coalition**. Its membership includes The Association of Washington Business, Senior Citizen's Lobby, Children's Hospital, American Academy of Pediatrics-Washington Chapter, Washington State Dental Association, Group Health, Children's Alliance, Washington State School Nurses Association, Washington State Hospital Association, Eldercare Alliance and the Washington State Labor Council. Now also working with the **Health Care Coalition for Children and Youth (HCCY)** on the passage of Cover All Kids legislation, which includes dental services for low to moderate income families.

Other States...

Medicaid Programs in 35 States Reimburse Primary Care Providers for Preventive Oral Health Services



The 'medical home' for dental care in Maine

Maine & US: Oral Health Status 2007, 2008

| | ME% | US% |
|--|------|------|
| % Adults (65+) No Teeth, 2008 | 21.8 | 18.5 |
| % Adults (18+) Teeth Cleaned, 2008 | 71.3 | 68.4 |
| % Children (0-17 y.o.) with both Med & Dent visit | 76% | 72% |

Child data from 2007 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Adult data from 2008 NOHSS, CDC, BRFSS

Maine & US: Health Professional Shortage Areas (HPSAs)

Underserved Population (%) Living in HPSAs (9/08)

| | US | Maine |
|---------------------|-------|-------|
| Primary Care HPSAs | 11.8% | 5.9% |
| Mental Health HPSAs | 18.7% | 9.5% |
| Dental HPSAs | 10.4% | 16.9% |

Maine & US: Distribution of Primary Care Physicians by Field, 2008

| | ME # | ME % | US % |
|-----------------------|-------|------|------|
| Internal Medicine | 614 | 29% | 35% |
| Family Practice | 903 | 43% | 29% |
| Pediatrics | 275 | 13% | 18% |
| Obstetrics/Gynecology | 203 | 10% | 12% |
| General Practice | 101 | 5% | 6% |
| Total Primary Care | 2,096 | 100% | 100% |

US Total PCPs = 385,508

Source: American Medical Association, Physicians Professional Data, copyright 2008.

From Problems to Solutions...

2001 – Meskin editorial in JADA

“Look who’s practicing dentistry”

“On the surface, it appears to be a “do-good” situation. After all, isn’t some prevention better than none at all? Actually, no — not when there isn’t evidence of a “true” dental/medical partnering agreement that ensures continuity of care for the child.”

MESKIN, L JADA 2001;132(10): 1352.

From Problems to Solutions...

2001 – Meskin editorial in JADA

“Look who’s practicing dentistry”

“It easily could lull the caregiver into a false sense of security, believing his or her child is receiving all necessary dental care.”

From Problems to Solutions...

2001 – Meskin editorial in JADA

“Look who’s practicing dentistry”

“The irony: medical auxiliary personnel, with minimal training, are performing preventive dental procedures. Meanwhile, state-employed dental hygienists cannot participate, since their dental practice act requires them to be under the direct supervision of dentists..”

From Problems to Solutions...

“National Health Care Reform”

Both House and Senate bills include provisions that require oral health services for children.

Bills establish an “Exchange” through which individuals and employers/businesses can purchase insurance. All plans that participate in the program *must include oral health benefits for children.*

From Problems to Solutions...

*“Beware the
unintended
consequences...”*

A call to action...

“Knowing is not enough;
we must apply.

Willing is not enough;
we must do.”

- Goethe

Thank You!



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www.bu.edu/creedd

Massachusetts Oral Health Advocacy Taskforce

Oral Health Achievements - **Watch Your Mouth Campaign**

Massachusetts, Maine, and New Hampshire

**WATCH
YOUR
MOUTH**

SPEAK UP FOR CHILDREN'S ORAL HEALTH

Massachusetts Oral Health Advocacy Taskforce

Getting children covered

Getting families covered

Massachusetts Oral Health Advocacy Taskforce

**The Oral Health Advocacy Taskforce is a
broad-based statewide coalition of
consumers, advocates, health care
professionals, academics, and insurers.**

**Goal of the Taskforce is to improve oral
health for all persons in Massachusetts
through evidence-based public policy
advocacy.**

Massachusetts Oral Health Advocacy Taskforce - Medicaid and SCHIP

Joint application: Medicaid and SCHIP

Elimination of face-to-interviews

Presumptive eligibility

Administrative verification at enrollment

12-month continuous eligibility

Massachusetts Oral Health Advocacy Taskforce - Medicaid and SCHIP

Dental 'carve out'

Third party administrator

Dentist as state Medicaid dental director

Outreach, outreach, outreach

Massachusetts Oral Health Advocacy Taskforce

Oral Health Achievements

Health Care For All v. Romney

In April 2000, Health Law Advocates filed a **class action lawsuit in federal court** on behalf of Health Care For All and several MassHealth families. The case, *Health Care For All v. Romney*, charged state officials with **failing to ensure access to dental care for MassHealth members**. Trial was held in October 2004 and a decision was issued on July 15, 2005. In her decision, US District Court Judge Rya Zobel ruled that the state was running its dental program for 500,000 Medicaid children in **violation of federal law**. According to the ruling, the state violated provisions of the federal Medicaid Act requiring "prompt provision of services, adequate notice and treatment at reasonable intervals," due in part, "from insufficient reimbursement." The **final remediation plan, signed on February 3, 2006, includes steps that would make it easier for families to get preventive care for their children, allow dentists to get appropriate payment for their services, and simplify the claims process for dental reimbursements.**

Massachusetts Oral Health Advocacy Taskforce

Oral Health Achievements

Formation of a Legislative Oral Health Caucus

Its purpose is to educate members of the General Court on the importance of oral health and its connection to overall health. To meet this goal the Caucus develops legislative, budgetary, and regulatory strategies to improve oral health policy in the Commonwealth.

Since its formation, the Caucus has met formally two to three times each year; meetings are scheduled and open to all members of the Massachusetts General Court and other interested individuals.

Massachusetts Oral Health Advocacy Taskforce

One in ten Black, Hispanic and low-income children in the third grade suffer from pain in teeth and mouth

More than 60 % of third grade children from low-income families suffer from dental decay compared to 33 % of children from higher income families

58 % of Hispanic third graders and 51 % of Black third graders suffer from dental decay, versus 36 % of white children

Massachusetts Oral Health Advocacy Taskforce

Oral Health Achievements

MassHealth dental benefits for all adults

In 2002, at the height of the state's fiscal crisis, **comprehensive dental benefits**, including exams, cleanings, fillings, root canals, and more, were **eliminated** for the majority of adults enrolled in the MassHealth program. In July 2005, as part of the FY06 budget, these important health **benefits were restored for pregnant women and mothers with children under the age of three** enrolled in MassHealth. Benefiting approximately 40,000 women across the Commonwealth, this restoration was an important step forward in the restoration of dental benefits for all adults enrolled in the MassHealth program. On April 4, 2006 – more than four years after the elimination – the House and Senate unanimously **reinstated adult MassHealth dental benefits as part of the broader health reform legislation**. Despite a Gubernatorial veto, the restoration of these important health benefits will soon become a reality as both the House and Senate, by overwhelming margins, both voted to override the short-sighted veto of the Governor.

Massachusetts Oral Health Advocacy Taskforce

Current Budget Priorities

Dental Care for Persons with Special Health Care Needs

Persons with special health care needs are among the most underserved in the Commonwealth. This population is made up of individuals with developmental disabilities including mental retardation, cerebral palsy, autism, epilepsy, cystic fibrosis, muscular dystrophy, closed head trauma, spinal cord injury, spina bifida, multiple sclerosis, congenital blindness, and congenital deafness. In Massachusetts, the majority of the special needs population is served by a nationally recognized public program administered by Tufts University that treats up to 16,000 people per year. **Inadequate reimbursement for dental services provided to MassHealth patients has placed this valuable program at risk.** Increased funding is necessary to maintain access to quality dental care for those with special health care needs in Massachusetts.

Line item: 4512-0500 / Estimated Cost: \$325,000

Massachusetts Oral Health Advocacy Taskforce

Current Budget Priorities

Dental Benefits for Certain Commonwealth Care Members

Massachusetts' historic health reform legislation and the creation of Commonwealth Care will undoubtedly improve the health of the Commonwealth. Unfortunately, Commonwealth Care plans for individuals with incomes that fall between 101-150% of federal poverty level do not include dental benefits. Oral health is a critical component of overall health and dental benefits should be included in those health insurance plans as well. Individuals enrolled in Commonwealth Care with incomes between 101-150% FPL do not contribute to premiums and are most vulnerable to the financial and social impact of dental disease and treatment. These individuals currently access dental services through the Health Safety Net Trust Fund, resulting in uneven access and higher treatment costs. Providing these individuals with dental benefits through Commonwealth Care would reduce medical and dental treatment costs and shift the cost from the Safety Net.

Outside Section amending Chapter 118H, Section 6: (a), changing 100 to 150. Estimated Cost: \$4.4 million