NGA Center for BEST PRACTICES

Issue Brief

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State Efforts to Improve Children's Oral Health*

Summary
Most children enjoy optimal oral health. For a significant number of children, bad oral health is a painful and chronic reality. Needlessly limited by a preventable disease, these children experience weight loss and fall behind in school and social development. By the time they get care, many must see specialists or be treated in a hospital operating room. Most children affected are from low-income families.

Most of these cases could be avoided, and states can use a combination of approaches to improve the quality of children's oral health. With regular access to competent care as well as prudent prevention and education, these children could experience the same high level of oral health as most children do. To this end, states are addressing the following problems:

The Problem

- Dental caries (tooth decay) is the single most common chronic childhood disease; five times more common than asthma and seven times more common than hay fever.
- Twenty-five percent of children suffer 80 percent of tooth decay.
- Poor children suffer twice as much tooth decay as their more affluent peers.

- **Promoting Education and Prevention.** Much of the disease experienced by children could be prevented with better personal care and water fluoridation. Several states have launched public awareness campaigns to educate parents and children about proper dental care and to build public support for children's oral health policy initiatives.
- **Increasing Coverage and Access.** Though many low-income children have dental coverage through Medicaid, most receive no preventive dentist visits**.** Many states are trying to strengthen the safety net by encouraging providers to participate in Medicaid and by including dental benefits in State Children's Health Insurance Programs (SCHIP). Any coverage expansions would increase state costs.
- **Enhancing the Dental Workforce**. Many states are trying to attract dentists to chronically underserved areas, yet the number of dentists graduating from dental school is decreasing nationally. To succeed, states are using loan forgiveness, tax credits, and other incentives and are trying to enhance dentist training to adequately address pediatric needs.
- **Improving Financing and Reimbursement.** Many providers refuse to participate in Medicaid because of the low rate at which they are reimbursed. Some states have increased provider reimbursements in Medicaid to attract new dentists as well as to bring back dentists who have stopped participating. As with coverage expansions, this strategy would increase state costs.
- **Improving the Quality of Data and Surveillance.** The lack of reliable state-level data often makes assessing and monitoring the oral health of children a challenge for states. States are working with their public health departments as well as local universities, policy institutes, and the Centers for Disease Control and Prevention to develop reliable methods to track the prevalence of dental disease.

Don't Most Kids Have Healthy Teeth?

Oral health conditions include a number of congenital or developmental anomalies, such as clefts, tumors, and abnormal teeth—but the most common childhood oral disease is tooth decay (known medically as dental caries). In fact, five to eight times more children suffer from caries than from asthma.[1]

The Cost

- More than 51 million school hours are lost each year to dental-related illness.
- Poor children suffer nearly 12 times as many restricted-activity days as children from higher-income families.

While most children enjoy optimal oral health, a minority of children experience chronic and severe dental disease. Eighty percent of tooth decay is concentrated in only 25 percent of children.[2] Solving this problem requires action on a number of policy issues.

Promoting Education and Prevention

One of the most encouraging opportunities relating to children's oral health is the opportunity for disease prevention. Prevention can largely be addressed through community water fluoridation, good personal care, and regular preventive dental visits. Fluoride is the most effective tool for caries prevention, even when set against regular brushing and flossing as well as dentist check ups. According to a study comparing fluoridated and nonfluoridated communities in the United States, Australia, Britain, Canada, Ireland, and New Zealand, fluoridated communities consistently experienced caries reductions of up to 40 percent when compared to their non- fluoridated counterparts.[3] The per capita cost of fluoridation in communities of 20,000 or more is 50 cents,[4] producing a net savings over restorative care, yet, 34 percent of community water supplies are not fluoridated[5]. This is often because in a vacuum of legislative action, the decision to fluoridate public water is made at the community level.[6]

- **Maine** has achieved fluoridation of 78 percent of its public water supplies, satisfying the U.S. Surgeon General's fluoridation goal. The state believes that fluoridation is a critical and cost-effective approach to preventing dental caries.

Other preventive measures—besides daily brushing with fluoride toothpaste and flossing—include fluoride mouth rinses, fluoride varnish, and dental sealants. A number of school and community-based programs provide fluoride mouth rinses and varnishes. Such programs have been effective in reducing childhood caries. Similar programs have been implemented to provide sealants, targeting particularly vulnerable school children.[7]

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[1] J. Crall et al., "Disparities in Children's Oral Health and Access to Dental Care," *Journal of the American Medical Association*, Vol.284, No. 20 (November 2000), 2625-2631.
[2] Ibid.
[3] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.
[4] http://www.cdc.gov/OralHealth/factsheets/fl-cwf.htm.
[5] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5107a2.htm.
[6] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.
[7] Ibid.

- A combined dental sealant and fluoride mouth rinse program showed strong results in **Guam**. Dental caries rates for children in Guam were more than twice those of children on the U.S. mainland. After a school-based sealant program was added to a mouth rinse program already in practice, children living on Guam began to experience caries rates comparable to those of children on the mainland.[8]

Several states and their partners have launched public awareness campaigns to educate parents and children about proper dental care and to build public support for children's oral health policy initiatives, underscoring the important link between oral health and the total well-being of the child. Recognizing the complexity of the actions required to bring about a change in public awareness and behavior, many of these programs build on strategic coalitions that bring relevant stakeholders to the table.

- In **Washington** state, the Watch Your Mouth campaign gained nationwide attention for its clever use of Public Service Announcements (PSAs**)** and coalition building to create public support for children's oral healthcare in the policy arena. Messages were tested in focus groups and in one-on-one interviews. Using the slogan "watch your mouth," the campaign used radio advertisements, posters, stickers, and pins to promote their cause. Materials were distributed to dentist offices, lobbyists, legislators, pediatricians, and other relevant parties. Tailored presentations were made available to interested community organizations for meetings. The campaign was launched by the Citizens' Watch for Kids' Oral Health, a partnership of Frameworks Institute; Washington Kids Count/University of Washington Human Services Policy Center; and Washington Dental Service, Inc. and funded by the David and Lucile Packard Foundation and the National Institute of Dental and Craniofacial Research/National Institutes of Health.

The Access Issue

- Twenty-five percent of poor and minority children never visit a dentist before entering kindergarten.
- Fewer than one in five Medicaid-covered children ever receive a single dental visit.
- Children from families without dental insurance are three times more likely to have unmet dental needs than children with either public or private insurance.
- Uninsured children are 2.5 times less likely than insured children to receive dental care.

Increasing Coverage and Access to Care

Poor children are three times as likely as their peers to have a dental need that is unmet, and fewer than 20 percent of children on Medicaid receive preventive dentist visits. This restricted dental access is largely the result of workforce inadequacies (namely a lack of dentists, especially those who treat Medicaid patients, and a lack of pediatric dentists) and a paucity of employer-sponsored dental insurance. Poor children who do not qualify for publicly funded dental benefits often lack coverage. Children with special needs are particularly vulnerable.[9]

These access issues can be addressed with a variety of solutions.

- States may provide a dental benefit to low-income children through the State Children's Health Insurance Program (SCHIP). Almost all states provide some dental coverage with SCHIP,[10] and some

[8] Ibid.
[9] J. Crall et al., "Disparities in Children's Oral Health and Access to Dental Care," *Journal of the American Medical Association*, Vol.284, No. 20 (November 2000), 2625-2631.
[10] General Accounting Office. HEHS-00-72. Oral Health: Dental Disease is a Chronic Problem Among Low-Income Populations. U.S. General Accounting Office, Report to Congressional Requestors. HEHS-00-072. April 2000.

have been extremely successful at enrolling providers and beneficiaries in SCHIP, which is proving to be a powerful tool to improve oral health access.

- All states that cover children with Medicaid provide a comprehensive dental benefit to enrollees through the age of 21.[11]
- Dental schools and community-based clinics provide dental care to many Medicaid recipients as well as the uninsured.
- In **Alabama**, the state mobilized dentists in the National Guard (GuardCare) to provide dental screening and treatment to over 500 adults and children in Dallas County.
- **Georgia** held an Oral Health Summit to create regional plans to improve access to dental services and expand oral health preventive services, especially for children. Healthcare providers, community advocates, elected officials, school nurses, educators, and representatives from the business community assembled to form seven regional planning-groups to build community-level relationships. The Georgia Oral Health Team helped plan the summit and facilitated the planning-group meetings. More than 130 people participated in the summit. A small continuation grant—provided with funds from the U.S. Department of Health and Human Services, Health Resources and Services Administration—will be given to the seven regional planning-groups to continue their work. Three regions will immediately receive grants of $8,500 a year for three years.

States remain committed to their coverage expansions for children. However, in difficult fiscal times, increased costs must be considered within the context of other state priorities and limited financial resources.

The Dental Workforce Issue

The nation's supply of dental professionals is on the decline, raising concern about the capability of the dental workforce to meet the emerging demands of communities and to provide required services efficiently.

Enhancing the Dental Workforce

The shrinking dental workforce is a serious concern for state policymakers. The number of graduating dentists declined from 5,756 in 1983 to 4,000 in 1990. This was due in part to the closure of seven dental schools and an overall reduction in class size of 40 percent. This fact is troubling when considered in the context of a rising U.S. population and the large number of dentists who will retire from private practice in the near future.[12,13]

Currently, 344 vacant faculty positions exist at 54 dental schools nationwide. Twenty-four of these are pediatric dentistry positions. This shortage has workforce implications and adversely affects access, as academic dentistry plays an important role in treating the uninsured through clinics, hospitals, and schools.[14]

The lack of pediatric dentists and general dentists trained to treat children is of particular concern for children's oral health needs. Unlike physicians, most dentists are generalists—and pediatric postdoctoral

[11] Ibid.
[12] Crall, James J., "Children's Oral Health Services: Organization and Financing Considerations," *Ambulatory Pediatrics*, Vol. 2, No. 2, supplement (March- April 2002), 148-153.
[13] Valachovic, Richard W., "Dental Workforce Trends and Children," *Ambulatory Pediatrics*, Vol. 2, No. 2, supplement (March- April 2002), 154-161.
[14] Luke, Gina. American Dental Education Association. Letter (memorandum) to author, 4 September 2002.

training is available for less than five percent of graduating seniors.[15] In fact, many states do not have pediatric dental residencies at all, and general dentists are rarely required to complete a clinical residency.

Nationwide, only 3,500 dentists (2.5 percent) specialize in pediatric dentistry.[16] This creates unique difficulties for children with special health needs who might require the services of pediatric specialists, even for routine preventive care. Both general and pediatric dentists are heavily concentrated in urban centers, magnifying the scarcity in rural communities.

Some states attempt to increase the numbers of practicing dentists by offering loan repayment and forgiveness or tax credits to dentists who will move to their state or to an underserved community. States are also trying to attract retired dentists to fill gaps in access for low-income patients.

- **Colorado** implemented a two-year dental educational loan repayment program for dentists and dental hygienists who agree to treat underserved populations. The amount of the loan repayment contract is based on the number of underserved patients seen on a monthly basis. Dentists and hygienists are also eligible to receive a credit for state income tax as long as they serve a minimum number of rural and underserved populations. Provided that there is a state surplus, the Oral, Rural, and Primary Care section of the Colorado Department of Public Health and Environment issues each provider a certificate of credit for the year's state taxes.
- The Financial Authority of **Maine** (FAME) Dental Education Loan Program provides up to $80,000 over four years in forgivable loans for Maine residents who agree to practice in underserved areas. Loan recipients must treat patients regardless of their ability to pay—and must accept Medicaid and SCHIP payments or payments based on a sliding fee scale. Similarly, the Maine Dental Education Loan Repayment Program provides up to $80,000 over four years of dental education loan repayment. To qualify, providers must meet the same requirements for treating underserved populations as recipients of the loan; however, non-residents are also eligible to apply for the repayment program.[17]
- **Minnesota** repealed the prohibition placed on dentists trained in foreign countries from taking the state licensing exam, provided the state Board of Dentistry determines that the dentist's training is equivalent to or higher than that provided by a dental college approved by the American Dental Association's Commission on Dental Education. The state also created a loan forgiveness program for students who practice in an office in which at least 25 percent of the patients receive publicly financed care. Legislation allows state officials to designate certain providers as "critical access" providers and therefore reimburse them at a higher rate than the usual Medicaid rate (currently set at 40 percent higher than the usual Medicaid rate).

States are also considering ways to improve the training of dentists to prepare them for patients with special needs, including children.

- Nearly every state has some sort of postdoctoral dental residency training program. Thirty-six states have pediatric residency programs.[18]

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[15] Ibid.
[16] Crall, James J., "Children's Oral Health Services: Organization and Financing Considerations," *Ambulatory Pediatrics*, Vol. 2, No. 2, supplement (March- April 2002), 148-153.
[17] http://www.famemaine.com/html/education/fameprogs.htm#dental.
[18] Luke, Gina. American Dental Education Association. Letter (memorandum) to author, 4 September 2002.

- **Delaware** is the only state that currently requires either a one-year General Practice (GP) Residency or a similar hospital-based program to meet the requirements for state licensure. Nationwide, there are 230 GP Residency Programs and 84 two-year Advanced Education in General Dentistry (AEGD) Residency Programs.[19]

Maximizing auxiliary personnel can increase access to preventive services for low-income children. In most states, the scope of practice for auxiliary personnel is quite restricted, even when the services necessary don't require a dentist. Some states are restructuring their Dental Practice Acts to maximize the use of dental hygienists and assistants to provide preventive services when clinically appropriate.

Further, a growing movement supports training physicians and nurses to assess dental needs and refer patients to dentists to receive treatment, better integrating oral health with the preventive care necessary for overall health. A pediatrician is generally the first health provider a child visits on a regular basis and is well positioned to provide guidance to parents about when it is appropriate to begin seeing a dentist.

- **Colorado** has worked to expand the role of hygienists in providing preventive services to low-income children by enabling independent practice hygienists to bill Medicaid directly.
- **Maine** changed the rules governing the practice of hygienists to allow them to practice in public health settings such as school health centers, hospitals, and public clinics without a dentist on site—provided that the hygienists have an established relationship with a dentist. The state believes this strategy offers great promise for addressing dentist shortages.
- **Minnesota** passed legislation in 2001 to allow dental hygienists to perform certain primary care functions without dentist supervision, provided they are employed by one of the following entities: hospitals, nursing homes, group homes, home health agencies, state-operated facilities, federal, state or local public health facilities, or community or tribal clinics. In order to qualify, the hygienist must meet prescribed practice experience requirements and must engage in a collaborative agreement with a dentist who authorizes and accepts responsibility for these hygienist services.
- **Missouri** passed legislation in 2001 to allow dental hygienists to practice in public health settings to provide fluoride treatments, cleanings, and sealants for Medicaid eligible children without dentist supervision. Public health settings will be defined jointly by the Department of Health and the Missouri Dental Board.

Improving Financing and Reimbursement Policies

Dental care accounts for 30 percent of all child health expenditures. However, for Medicaid children this spending rate drops to 2.3 percent. Under-funding of dental services and the accompanying decline in dentist participation is a chronic problem for Medicaid programs.[20]

A dentist's overhead costs can be very high. In fact, office costs represent 65 to 70 percent of a dentist's earnings.[21] This reality combined with the fact that many dentists find Medicaid's administrative procedures for reimbursement to be unduly burdensome and that the no-show rate can be high for a

[19] http://www.adea.org/CPPA_Materials/Factsheets/dental_residencies_facts.htm.
[20] Edelstein, Burton L., *Crisis in Care: The Facts Behind Children's Lack of Access to Medicaid Dental Care* (Washington, DC: National Center for Education in Maternal and Child Health, May 1998).
[21] D. Gregory Chadwick. "Issues Regarding Children's Access to Oral Health." Testimony before the Subcommittee on Pubic Health, Senate Committee on Health, Education, Labor, and Pensions, on behalf of the American Dental Association, June 25, 2002.

Medicaid patient, leads a large number of dentists to decline participation in the program. While increasing dentist reimbursement rates in Medicaid can prove to be an effective strategy, states might not be in a position to do so in the current fiscal climate.

- A number of states have raised their dental reimbursement rates based on fees charged by dentists in the private market—to a level that seventy to eighty-five percent of dentists consider to be the same as or greater than their usual fee. These states include **Alabama**, **Delaware**, **Georgia**, **Michigan**, and **South Carolina**.[22]

These states have enjoyed substantial increases in dental visits, claims submitted, and providers participating in their Medicaid programs. Georgia experienced a 63 percent increase in providers participating in Medicaid and Michigan experienced an 88 percent increase in dental visits nearly a year after the increase took effect.[23]

- **Missouri** passed legislation in 2001 mandating that Medicaid reimburse dentists, dental hygienists, and pediatricians who provide fluoride treatments, cleanings, and sealants for Medicaid eligible children in public health settings at 75 percent of the usual and customary cost—to be determined by the Division of Medical Services.

Improving the Quality of Data and Surveillance

When beginning an oral health initiative, states often find that the lack of reliable state-specific data regarding the amount and extent of dental disease makes it difficult to proceed. Many states find innovative ways to address this issue, such as working with their health departments, local universities, and policy organizations to survey and estimate the status of oral health in their states.

- In **New Hampshire,** the Department of Health and Human Services partnered with the Department of Education to conduct a statewide survey of the oral health status of third graders in public schools during the 2000-2001 school year. The survey used methodology described in the Basic Screening Surveys, a standardized set of surveys used for data collection.[24]

- The Centers for Disease Control and Prevention collaborated with the Association of State and Territorial Dental Directors to develop the National Oral Health Surveillance System which will provide state- and national-level data to public health officials regarding the incidence of oral disease, the use of oral health delivery systems, and the prevalence of water fluoridation.[25]

Conclusion

States are improving children's oral health by addressing issues of prevention and education, access to care, the future of the dental workforce, financing and reimbursement for providers, and data surveillance. States are also working hard to build coalitions composed of the necessary stakeholders and to build public support for children's oral health policy initiatives. While some issues such as coverage expansions and reimbursement increases might be difficult at the moment because they raise costs, some other strategies can be relatively cost neutral. States are optimistic that with the right plan for action, someday all children can enjoy optimal oral health.

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[22] Edelstein, Burton L., communication with author, 17 April 2002.
[23] Ibid.
[24] "Initiatives in Oral Health," *Schoolhealth Program News*, vol. 7, no. 2 (May 2002), Education Development Center, Inc., Newton, MA.
[25] Ibid, available at http://www.cdc.gov/nohss/.

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