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INVITED PAPER

Breaking the cycle in Maryland: oral health policy change in the face of tragedy

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Summary

In response to the death of a young child, efforts by many partners have enabled Maryland to institute oral health reforms that ensure that low-income children remain visible and have continued access to dental services. This paper shows how proponents of oral health in Maryland used issues that were already on the oral health policy agenda to break the cycle of nonaction and become a role model for other states. Deriving from the knowledge and advice of an advisory committee, Maryland administrators and state and federal legislators, with the support of many community partners, took appropriate action to elevate the oral health agenda. Maryland continues to address oral health issues, ensuring that the policy agenda is inclusive of all its citizens.

Introduction

Throughout history, tragic events that receive public attention have played a role in setting policy agendas. Thomas A. Birkland observed that “A disaster can often do in an instant what years of interest group activity, policy entrepreneurship, advocacy, lobbying, and research may not be able to do: elevate an issue on the agenda to a place where it is taken seriously in one or more policy domains” (1). Administrators and policy makers are forced to examine the tragic event and determine what could have been done differently.

On February 25, 2007, Maryland experienced a preventable tragedy that heightened awareness of shortcomings in the state’s oral health care delivery system. Deamonte Driver, a 12-year-old Maryland boy, died as a result of an untreated dental infection that spread to his brain. Access to routine dental education, prevention, and treatment measures could have saved this young life. Deamonte’s death elevated issues that were already on Maryland’s oral health agenda. A series of articles in the Washington Post sparked global media attention that spurred collaboration of oral health proponents, policy makers, and legislators to prioritize the oral health agenda (2).

After 4 years of effort and commitment by many in the public and private sectors, including the leadership of Governor Martin O’Malley and Maryland’s Congressional leadership, notably Senator Barbara Mikulski, Senator Ben Cardin, Congressman Elijah Cummings, and Congressman John Sarbanes, Maryland is now in the forefront in efforts to make sure that the most vulnerable children have access to dental prevention and treatment services. This paper examines how one state responded to a preventable tragedy and developed a sense of urgency, partnership, and action regarding its oral health policy agenda. This is a story of Maryland’s Department of Health and Mental Hygiene (DHMH) oral health efforts prior to Deamonte Driver’s death in February 2007 and the actions that have followed since that time to attempt to avert another tragedy.

Background

Before tragedy

In the late 1990s, Maryland was reported to be among the lowest states in the country for average fee per dental claim and average cost per recipient in its Medicaid program

resulting in poor access to dental care. In 1997, approximately 19 percent of Medicaid-enrolled children received an oral health service compared with the national average of 27 percent (3). Not only were the dental reimbursement rates low, but only half of Maryland jurisdictions had public health (safety-net) dental services.

In 1997, Maryland Medicaid instituted a managed care system for its programs, which enlisted multiple managed care organizations (MCOs) who then contracted with a number of dental managed care vendors. This programmatic change triggered many Maryland public health dental programs to stop providing dental services because it was expected that the change to MCOs would create more participation by the private dental sector. Accordingly, plans were drawn up for state funding to be withdrawn from county dental clinics rather than expand this already modest safety-net system that existed in the state. When the managed care program never resulted in a significant new infusion of private practicing dentists in the Medicaid program, Maryland's Health Department (DHMH) did not go through with its plans to reduce funding for its county dental programs.

Up to this time, the Division of Dental Health of DHMH had no budget, few existing partnerships or oral health advocates, and depended solely on oral health grants funded by DHMH's Division of Maternal and Child Health. As a result, there were few dental public health programs, policies, and surveillance initiatives at the state level. When the Division was reestablished as the Office of Oral Health (OOH) in 1997 because of a supportive new health secretary, its renewed mission encompassed an agenda aimed at reducing the oral disease burden in Maryland.

Also in the late 1990s a concerned state legislator commissioned individuals from academic, governmental, and advocacy organizations to develop a 5-year legislative plan to address oral health access in Maryland. This plan laid the groundwork for developing the advocacy and policies that would eventually take hold after the death of Deamonte Driver. The legislation (Senate Bill [SB] 590 – 1998) placed the OOH in statute, called for a state Oral Health Advisory Committee, mandated an increase in access to Medicaid dental services, and required statewide oral health surveillance of Maryland schoolchildren (4).

Five other legislative efforts were approved by the state legislature and became law: SB 791 (2001) convened a statewide oral cancer prevention campaign (5); SB 519 (2000) developed the Maryland Dent-Care Loan Assistance Repayment Program to enable loan repayment to dentists who incorporated Medicaid children into their practices (6); House Bill (HB) 1309 (2002) allowed pediatric dentists with foreign dental licenses who practiced for 2 years in Maryland safety-net clinics to be eligible for a state license (7); SB 181 (2007) provided more funds for the dental safety-net clinics in Maryland and required that the state has a full-time dental director in its oral health office (8); and SB 568 (2007) allowed public health dental hygienists working for public health programs to provide their scope of services through general supervision and without the dentist having to first examine a patient (Figure 1) (9).

These legislative successes provided some resources to the OOH. More importantly, they empowered the office to address key dental public health education, prevention, and access initiatives. This rich legislative period cemented an overall consensus and bond among academic, governmental, and advocacy groups regarding needed actions to improve access to Medicaid dental services. While these legislative efforts were barely being heard above other interests, the death of Deamonte Driver served as the catalyst for bolder initiatives of the Dental Action Committee (DAC) and its recommendations that would follow (10).

After tragedy

Deamonte Driver's death in February 2007 shocked Maryland administrators, legislators, and the public in general. Within 3 months, DHMH's Secretary John Colmers convened the DAC and charged it with making recommendations to reform children's access to oral health care in Maryland. By using the previously developed 5-year legislative plan (11), the DAC was able to quickly respond to the secretary's charge. In September 2007, the DAC report was produced with seven proposed recommendations (Table 1), many of which had been advocated in previous years but without the catalyst needed to be acted upon (10). These recommendations, which were designed to work in tandem with each other, were primarily based on other state's best practices and the expertise and experience of organizations such as the Children's Dental Health Project and Association of State and Territorial Dental Directors (ASTDD), among others.

By October, all of the DAC recommendations were supported by Secretary Colmers and Governor O'Malley. The governor then approved funding for this oral health agenda in his executive budget in January 2008 despite a dire economic climate. Medicaid payouts for dental claims increased from $55.4 million in Calendar Year (CY) 2008 prior to the enactment of the reforms and the carve-out of the Medicaid dental program to $137.6 million in CY 2010 once the reforms were fully in place (12). However, this still represents less than 1 percent of Medicaid budget appropriated by the state. By April 2008, with the aid of key state legislators, Maryland's legislature passed all the governor's budgetary oral health initiatives, as well as other key enabling legislation addressing the DAC recommendations.

After passing the legislative hurtles, DHMH in conjunction with many partners acted on all seven recommendations leading to numerous reforms to Maryland's oral health care

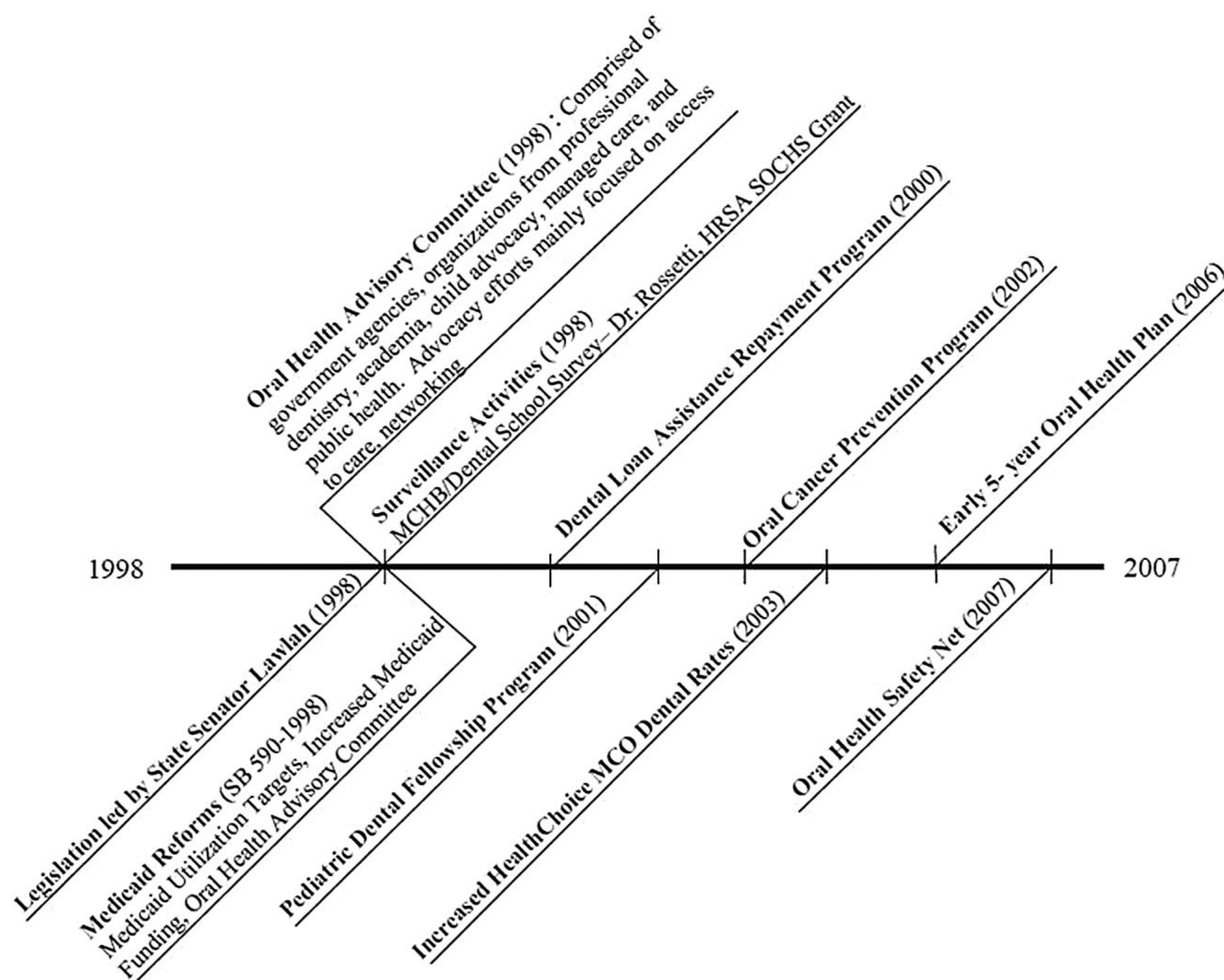

Figure 1 Maryland's experience: planting the seeds (1998-2007).
MCHB, Maternal and Child Health Bureau; MCO, managed care organization; SB, Senate Bill.

system including support for the OOH, a reformed Medicaid dental program, and numerous policy and programmatic initiatives. In retrospect and perhaps not realized at the time, the success that was to follow implementation of these reforms would not have occurred without the strong private and public partnerships that were developed and then cemented during the DAC deliberations. Fueled by a strong collective commitment to oral health and the growing realization that only through collaboration could success be accomplished, consensus was achieved to convert the department convened DAC into an independent coalition, the Maryland Dental Action Coalition (MDAC), in 2009.

Significant progress to oral health access has been made as the result of the DAC recommendations that were instituted beginning in July 2008 (12). The number of dentists participating in the Maryland Medicaid program, newly entitled the "Maryland Healthy Smiles Program" and solely administered by DentaQuest, Inc., increased from 649 in August 2009 to 1,190 in August 2011, representing 29 percent of all licensed dentists. Access for children ages 4-20 enrolled 320 days or more in the Medicaid program in the past year increased from 19.9 percent in 1997 to 63.9 percent in 2010. The safety-net oral health care delivery system also was better funded so that residents in every Maryland county had access to oral health care in either a local health department, a federally qualified health center, or a "look-alike" federal program (12).

New policies and initiatives: beyond the DAC recommendations

One of the legislative efforts, the Oral Health Safety Net legislation (SB 181) (8), passed in 2007 followed ASTDD recommendations that each state should have a strong, established state oral health office with a full-time dental

Table 1 DAC's Recommendations in 2007 and Current Status (12)

DAC's recommendation	Status
1. Initiate a statewide single vendor dental Administrative Services Only provider for Maryland.	Medicaid dental services were "carved out" of the managed care Medicaid program and awarded to a single vendor in 2009. Credentialing, application process, and other bureaucratic issues simplified.
2. Increase dental reimbursement rates to the 50th percentile for the American Dental Association's (ADA) South Atlantic region charges, indexed to inflation, for all dental codes.	Governor's budget supported recommended rate increases for each of three fiscal years at the ADA 50th percentile median fee. Only the first of three increases was enacted due to the economy.
3. Maintain and enhance the dental public health infrastructure by ensuring that each local jurisdiction has a local health department dental clinic or a community oral health safety-net clinic serving low-income populations.	OOH budget included funds to increase the oral health safety net. Residents in every county in Maryland now have access to a public health safety-net dental clinical program.
4. Establish a public health level dental hygienist to provide services within their scope of practice without a dentist present or having to see the patient first.	Enabling legislation passed in 2008 to create a new Public Health Dental Hygienist category. This legislation has contributed to public health programs utilizing these dental hygienists in clinical and outreach programs.
5. Develop a unified oral health message for use throughout the state to educate parents, caregivers, and health care providers of young children about oral health and the prevention or oral disease.	In 2010, the OOH received funding from the Centers for Disease Control and Prevention for an Oral Health Literacy Campaign, scheduled to launch in February 2012.
6. Systematically provide dental screenings and case management for public school children.	The Maryland Dental Action Coalition received a Kaiser grant to pilot a school-linked screening and case management program in one county.
7. Provide training to dental and medical providers to enhance their skills in establishing a dental home for children.	In 2009, Medicaid began reimbursing medical providers for applying fluoride varnish. Over 34,000 fluoride varnish applications provided to children aged 9-36 months from 347 trained providers. Six hundred forty-three dentists have been trained in pediatric dental principles.

DAC, Dental Action Committee; OOH, Office of Oral Health.

director. State oral health programs serve as a focal point for a state's dental public health activities and keep the issue of oral health visible to law makers, health experts, and the public (13). However, state oral health programs must have the necessary capacity and expertise to effectively achieve this mission. It was therefore critical for Maryland, which severely lacked this needed level of dental public health infrastructure throughout its history, to correct this structural deficiency. As such, in order to carry out these recommendations, DHMH hired a full-time dental director for the OOH in early 2008.

In 2008, the OOH also received a 5-year (2008-2013) $1.2 million infrastructure and capacity building grant under the State-Based Oral Disease Prevention Program from the Centers for Disease Control and Prevention (CDC). This funding and guidance has enabled the OOH to establish a strong oral health program infrastructure with the capacity to plan, develop, implement, and integrate evidence-based health promotion and disease prevention programs. The program, now in its fourth year, employs an Epidemiologist/Evaluation Scientist, Water Fluoridation Coordinator, and a Dental Sealant Program Coordinator, among other positions.

The first requirement of the newly hired epidemiologist was to produce a burden of oral disease document (14) and develop a surveillance plan. These documents provide an overview of the status of various oral diseases in Maryland and highlight the gaps and disparities that exist with respect to demographic and geographic elements that impact oral health behaviors and outcomes, as well as access to education, prevention, and treatment services.

In 2010, the OOH partnered with the University of Maryland Dental School on a Dental Sealant Demonstration Project. Findings from the project piloted in 10 schools have shown the need for a statewide dental sealant program (15). The OOH Dental Sealant Program Coordinator is currently developing a best practice statewide dental sealant program in order to implement an evidence-based preventive service that will help eliminate oral health disparities.

In addition to providing information on the public health benefits of community water fluoridation, the OOH Water Fluoridation Coordinator partnered with the Maryland Department of Environment to address and monitor statewide water fluoridation efforts at the municipal water operations level. Each month, the OOH submits reports to the CDC Water Fluoridation Reporting System to ensure proper monitoring of fluoridation levels in Marylander's water. Currently, according to the CDC, Maryland ranks number one in the United States for community water fluoridation with 99.8

percent of its residents on public water systems receiving fluoridated water (16).

The OOH continues to expand clinical and school-based/linked education, prevention, and treatment programs, as well as provide support for statewide prevention initiatives including a successful program to reimburse Medicaid medical providers who apply fluoride varnish as part of their scheduled well-child visits. As of August 2011, 347 medical providers have enrolled with the Medicaid program to provide dental screening, referral, and fluoride varnish. Since the start of the program in July 2009 through July 2011, the program provided 34,533 fluoride varnish treatments to children ages 9-36 months (12). The statewide fluoride varnish program benefits from a strong partnership between OOH, MDAC, the Maryland Medicaid program, National Maternal and Child Oral Health Resource Center, the University of Maryland Dental School, and DentaQuest, Inc. It was developed as the result of a successful pilot program in Baltimore City led by Dr. Joshua M. Sharfstein, when he was the Baltimore City Health Commissioner, in 2007 (17). Dr. Sharfstein, who is the current DHMH secretary, helped convince DHMH to implement the statewide fluoride varnish program. The medical/dental interface that this program provides also is the first step toward a health home for Marylanders.

In May 2011, MDAC released Maryland's State Oral Health Plan (MOHP) (18). The plan established a systematic statewide oral health policy agenda and road map for Maryland to achieve three priority areas of focus in the state including access to care, prevention, and oral health education and literacy. MDAC also cosponsored the recent Maryland Oral Health Summit which used the MOHP as the centerpiece of the meeting for implementation and policy prioritization. With its newfound expertise in epidemiology and evaluation, OOH will collect and/or provide the necessary data and analysis to assist MDAC in monitoring the progress of the MOHP and the overall state oral health policy agenda.

The OOH also is partnering with the MDAC in the development of the Maryland Oral Health Literacy Campaign, a social marketing initiative (19) funded by the CDC. This comprehensive messaging campaign hopes to elicit behavior change among its target population, low-income pregnant women and mothers of children 0-6 years of age, regarding prevention of early childhood tooth decay and the need for a dental visit within the newborn's first year of life (19).

Perspective: why it worked in Maryland

Research has shown that when a tragic event influences an agenda, there is an "interaction between the event, the nature of the event, and the composition of the community of actors who address the policy issues or problems revealed by the disaster" (20). DHMH and other community leaders had previously identified gaps in the oral health care delivery system in Maryland and had made some progress. Between 1998 and 2007, Maryland began planting the seeds to building its strong partnerships and advocacy (Figure 1). However, despite these gains, it still took the death of a 12-year-old Maryland boy from a dental infection to galvanize the community and to create the opportunity for sustainable action and systems change. One also cannot discount certain fortuitous circumstances as Maryland steered its path toward "righting the ship."

It was "lucky" to have the right people in place at the right time who understood the true meaning of the tragedy from both personal and policy perspectives and who had the courage and political will to take action. Furthermore, Maryland's proximity to the District of Columbia allowed for prominent media outlets to draw national attention to this tragic event. Louis Pasteur has said that "chance favors the prepared mind." By Maryland advocates being prepared and having a "shovel-ready" plan, they were able to immediately frame this tragic event in a manner that would create a sense of urgency. Equally important, the oral health advocates were able to present a plan that everyone could easily embrace. In April 2008, less than a year after the DAC recommendations were submitted, the governor's DAC budget initiatives and other DAC-related legislation were passed and signed into law.

The collaborative and partnership approach that the Maryland oral health advocates used enabled work to be completed quickly and efficiently. What may set Maryland apart from other states is the strength of its public and private partnerships which coalesced around the credibility and trust garnered through years of networking and other collaborative activities prior to the death of Deamonte Driver. The support and advocacy by the Maryland State Dental Association, Maryland Academy of Pediatric Dentistry, the Maryland Dental Hygienists' Association, and others were critical in encouraging dentists' participation in the Medicaid program and in expanding the dental public health infrastructure. These efforts were facilitated by DentaQuest, Inc. who created a new culture of responsiveness, transparency, and accountability in the Medicaid dental program.

The transition of the DAC into the MDAC furthered the successes of the initial collaborations and partnerships. The MDAC advocacy activities in the 2011 legislative session (Table 2) show the continued impact of the oral health advocates on oral health programs in Maryland. Collaboration through the MDAC continues with expansion of partnerships including the University of Maryland School of Dentistry, the University of Maryland at College Park, the School of Public Health, the National Museum of Dentistry, the Maryland Oral Health Alliance, the Maryland State Department of Education, the Deamonte Driver Dental Project, and DentaQuest, Inc. The Maryland Healthy Smiles Program also has embarked on a major "Dental Home" Initiative in July 2011 to recruit more Medicaid-eligible enrollees into the program.

Table 2 MDAC Legislative Activities – Maryland General Assembly 2011 Sessions

Bill no.	Short title	MDAC position	Status
SB 889	Dentists – informed consent – removal of materials containing mercury	Oppose in testimony	Defeated – rejected by the Health Committee
SB 886	Dentists – advertisements – materials containing mercury	Oppose in testimony	Defeated – rejected by the Health Committee
SB 578/HB 354	Dentists and dental hygienists – licenses, temporary volunteer licenses, and temporary dental clinic permits	Support by letter	Passed
HB 901	Fluoride levels in drinking water – study	MDAC visited the office of the legislator sponsoring the bill and convinced him to withdraw the bill prior to its scheduled hearing date.	Withdrawn
Budget Hearing	Medicaid budget cuts hearing	Testimony against budget cuts in both the House and the Senate	The recommendation by the Department of Legislative Services budget analyst to cut the Medicaid dental rates was rejected by both the House and the Senate budget committees.

HB, House Bill; MDAC, Maryland Dental Action Coalition; SB, Senate Bill.

Conclusion

In the wake of Deamonte Driver's death, Maryland legislative and administrative leaders, and the oral health advocacy community partnered to take part in one of the great successes in oral health access in the past 10 years. In the late 1990s, Maryland had one of the worst records regarding oral health care for its underserved population. In 2011, the Pew Center on the States ranked Maryland as the top state in the country for oral health (21). We now face the task of keeping oral health as a top public health priority and making sure every man, woman, and child in Maryland has timely access to oral health education, prevention, and treatment services regardless of social economic status.

Somewhere out in our midst is another Deamonte Driver. Through a lack of education, income, or inattention to the risks of oral disease, another vulnerable child or adult suffers preventable pain and risks avoidable consequences. Through will power, action, and strong leadership, Maryland has made that unacceptable. We must continue to expand our statewide prevention programs and ensure that all Marylanders have access to a dental home, including children, adults, senior citizens, and special needs populations. Only through constantly raising the bar on what we now call success in oral health care can we, as a state, honor Deamonte's legacy and prevent another child's death from oral disease, today and for generations to come. Moreover, hopefully, other states will not have to wait for one of their own to die tragically and needlessly and instead, have the foresight to act upon Maryland's example to be more proactive in breaking their own cycles of oral health policy inertia.

Conflict of interest

The authors declare no conflict of interest.

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