COMMENTARY

Investing in success versus paying for failure: Maryland oral health case history

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> Our children are the living messages we send to a future we will never see.
>
> Rep. Elijah Cummings (D-MD)
> October 20, 2011

Between 1980 and 2000, for every $1.00 spent on Texas higher education, $7.00 was spent on Texas corrections (1). As a society, why are we more willing to pay for failure than invest in our residents' success? And why does it take the death of a child from a preventable disease like dental caries to finally mobilize a state and its citizens to take action to improve oral health?

As we have heard at the Maryland Oral Health Summit, it took the tragic death of a young boy, Deamonte Driver, from an infection caused by untreated dental caries to change the public will in Maryland and create an appetite to fund oral health preventive, education, and care delivery initiatives. First, enabling legislation, although unfunded at the time, and an Action Committee which was in place, provided a framework and structure to act quickly when public will, appetite, and energy align to support these actions.

Second, I applaud the state of Maryland for funding the initiatives that were outlined by the Action Committee. The state mobilized various funding sources to address the needs implementing an oral health surveillance system, staffing the state Department of Oral Health, working to better understand and improve oral health literacy, and increasing reimbursements to dentists to provide dental care to Medicaid patients.

As we have since seen, other tragic deaths from dental diseases have occurred but have not resulted in the same action as we have seen in Maryland. Access to needed dental care is an issue almost every state is addressing in some form, as are health professional associations, foundations, and local dental societies (2-6).

As we reflect on Maryland's activities and how they made a difference, ideas/learnings from Maryland have emerged that may work in other communities. To this end, I offer the following considerations and recommendations:

- Develop a model template for enabling legislation and a Dental Action Committee for each state. Even if unfunded, it provides an infrastructure that facilitates action quickly should it be needed. Oral health success results from both short- and long-term investments.
- Our long-term investment in oral health must remain population-based preventive and education measures. Community water fluoridation is facing renewed challenges as states and local communities attempt to balance their budgets. We MUST not trade immediate balancing of state or local budgets for the long-term health of our population. The short-term trade-off will result in increased costs to the state Medicaid programs to care for children and adults who have resultant pain and suffering from dental caries.
- Our short-term investments must continue to fund and provide oral health services for children and vulnerable populations who currently suffer from dental diseases. We cannot abandon them and run the risk of serious adverse health consequences, needless pain, suffering, and decreased life potential. A recent study showed that children in North Carolina who have poor oral health were three times more likely to miss school as a result of dental pain and more likely to perform poorly in schools (7).
- We must continue to strengthen our safety net of dental care delivery by enabling them to increase their effectiveness and efficiency, through programs like Safety Net Solutions.
- I applaud the support provided by the communities of interest, the dental public health community that served as the convener, the private practice dental community, the

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university community, patient advocates, and policy makers. It clearly demonstrates that when people from all realms come together, much is possible. It truly does take a village to improve the oral health of the population.

As Rep. Cummings noted in his address to the attendees, "synchronize your conscience with your conduct." The Maryland Oral Health Summit demonstrated that, by partnering together, they helped to insure that other children do not suffer from the same fate as Deamonte Driver.

Finally, when will we recognize that oral health is an economic development issue? Without good oral health, children and adults do not have the same employment opportunities as those who have good oral health. Can we as a society make a commitment to continue to invest in the oral health success and life potential of all children and adults throughout our society, rather than continue to pay for failure?

Conflict of interest

The author declares no conflict of interest relevant to the submitted work.

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

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Maryland state public health policy makers knew for nearly a decade that the Medicaid dental program was not meeting the needs of the state's most vulnerable children. Only 19% of the Medicaid-enrolled children had received dental care. They even knew the reasons why – low reimbursement rates, an insufficient network of dental providers, and a weakened public health infrastructure. A policy and program agenda, established by a champion state legislator created a sound strategic plan to address the oral health access issues. But funding streams were directed to other, seemingly more pressing issues. As a result of these circumstances, a vibrant young boy, by the name of Deamonte Driver, lost his life for reasons no one will ever be able to justify.

"It's just a cavity." They say. But for Deamonte, it was a dental infection gone awry.

Until policy makers, program administrators, healthcare providers and the general public recognize that dental caries, or what most continue to call "cavities," is a significant debilitating chronic disease, the risk of this event reoccurring is real. The Maryland Dental Action Committee's Recommendation to develop a unified oral health message could not be timelier. In order to move the masses, revolutionize opinion, and transform public policies to reflect the true deadly potential of dental caries, underlying perceptions must change. The Health Belief Model reminds policy makers and healthcare professionals that health behaviors are affected by an individual's perceived susceptibility and perceived severity of a disease. Likewise, ingrained public perceptions sway political agendas

and affect funding allocations to public programs. Because the prevalence and severity of dental caries disproportionately affects the low-income and minority groups, perceptions associated with this disease and its risk are skewed.

The word "cavities" is a problem. It is just not scary enough. It does not grab, strike, or inflict a need for action by individuals or policy makers. Healthcare officials have long recognized the association of labels, health beliefs, and health behaviors. Public service campaigns such as "The Silent Killer" and "Know Your Numbers" have been highly effective in changing perceptions and subsequently behaviors. For individual and public behaviors to change, including those by policy makers and program administrators, perceptions must change too. The term "cavities" just is not working. Dental caries is serious. Its potential is significant – perhaps a name change will help make the point.

But changes in perception and an oral health literacy campaign are not enough. Concrete measures, similar to the ones that the Office of Oral Health and state Medicaid office introduced following this tragic event are critical. Maryland's move to a single vendor dental administrator for the Medicaid program should be praised. Since its inception, it continues to demonstrate an effective means to increased efficiency within the system. Many states are moving toward managed care. Policy makers should consider carefully the pros and cons of single versus multi-vendor approaches.

Maryland's effort to expand the dental safety net will help to assure more timely receipt of dental services. Those newly involved in this effort however, should seek technical assistance in dental safety net practice management to assure quality and efficient delivery of services within the safety net setting.

Maryland officials also passed legislation which created a new public health dental hygienist category. This measure, aimed at increasing access to preventive dental services, expands the scope of services by dental hygienists. But if such a measure is not embraced by the state Medicaid agency, and services are not directly billable or reimbursed, then the integrity and sustainability of the program is potentially compromised. Administrators in the Medicaid agency should act to assure that current policies and administrative rules are aligned with the new practice act, so that advances and programs established by the Health Department will be truly effective.

Integrating oral health into primary care is long overdue. This approach requires a comprehensive understanding of the two systems, the independence that both have traditionally experienced and the recognition that the whole is truly better than the sum of its parts. Maryland's strategy to promote systems development of the medical–dental interface through education and training of dental and medical providers is significant. This collaborative and coordinated approach will not only improve the quality of oral health, but overall health and well-being. Further, reinforcing this effort through Medicaid reimbursement will surely enhance its potential success. Changes in practice will take time for widespread adoption, but it is clearly the path toward improved and coordinated health care.

All of the recommendations and implementation strategies that Maryland has undertaken to date have begun to affect positive change. While intentions to continue these efforts are sound, it should be noted that states continue to face budget challenges. Medicaid directors and dental program managers will continue to wrestle with decisions aimed at providing the right care, for the right individuals at the right time. The time to embrace evidence-based prevention and chronic disease management in dentistry is now. With Health Care Reform just around the corner, efforts for ongoing education, sharing of information, and coordination will be the key in helping to assure that quality decisions and programs are upheld.

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The author declares no conflict of interest.

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

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In response to a tragedy, change is often made to ensure that such an event never occurs again. Too often the response is narrowly focused on the exact dimensions and details of the past unwarranted circumstance and fails to cover broader implications and possibilities. We try to prevent the second strike of lightning but fail to take full precautions against a storm. Maryland experienced a most regrettable incident but has responded in a targeted manner to prevent a reoccurrence and also broadened the scope of its response to be better prepared for positive action in the future. The Maryland model is impressive and should serve as guide for other states, independent of whether those states have had remotely similar tragic experiences.

An important lesson is drawn in the Background of the paper; that lesson is a critical reminder. The interest, involvement, and support of a key state legislator in issues of oral health was fundamental to creating the infrastructure that led to the development of a 5-year legislative plan, which then resulted in landmark national legislation. These critical actions were taken prior to the tragic event. However, with a foundation in place, decisive action could be taken. The message for oral health leaders and advocates is that they must be engaged with political leaders to inform and educate them with the purpose of developing legislative "champions" for oral health. Success in this regard takes time and patience, a steady, consistent approach and willingness to become involved in other issues important to legislators in hopes that the situation will lead to an opportunity to bring focus to oral health issues as well.

Regardless of these impressive and remarkable achievements in Maryland, and independent of their unfortunate genesis, it is the ensuing steps that may be the most challenging. For the changes to have traction, be sustained, and be judged as effective over time, careful attention must be paid to evaluation of their effectiveness as well as documentation of the differences that the policy and program changes have made regarding the oral health status of children in Maryland. It is in the domain of evidence that such initiatives often fall short. Legislators, particularly the "champions," want to know and have evidence that what they have worked for and developed has made a difference and improved the lives of people and the quality of life in their communities.

The data and the personal stories must be gathered and analyzed in the context of before and after evidence and measures. The evaluation effort should be prominent and undertaken vigorously. However, experience tells us that specific funding is typically not provided for adequate evaluation; sometimes proper expertise is not available for rigorous evaluation. The strength and resources to undertake the necessary evaluation may be found in the richness of the coalition partnership that has been formed around oral health in Maryland. A broad-based evaluation methodology, engaging numerous partners, is also another way to further promote and galvanize interest in and support for oral health.

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