COMMENTARY

The three-legged stool of success for states

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In the corporate world, one climbs the ladder of success. Public health, however, operates on a smaller stage. So, a state dental program must first walk up three or four steps onto the stage upon which sits the "*three-legged stool of success*." The Isman *et al*. article featured Association of State and Territorial Dental Directors resources that provide a great set of floor lights to guide state dental programs to the steps in an otherwise dark auditorium called "the real world, early in the 21st century." Others have called for different approaches to support state dental programs, such as through infrastructure efforts. In this metaphor, this collectively represents a handrail to help states up those few steps to the stage and the stool. Although they are good processes, neither the lights nor the handrail guarantee ascension because it is no easy task for a state dental program to sit squarely on the *three-legged stool of success*, and even more difficult to do so for very long – but states can increase their odds.

The three legs of the stool all start with the letter "C" – chutzpah, connections, and celestial alignment. According to the Merriam-Webster dictionary, the Yiddish word chutzpah originated in the late 19th century and means "supreme self-confidence" (synonyms include nerve and gall). Connections, in terms of the stool, refer to what the dictionary calls "an acquaintance who has influence, especially in the business or political world." For me, celestial alignment means that the right climate for action exists – even if it is for the wrong reason (e.g., the death of Deamonte Driver). Therefore, to successfully create and sustain a system of private and public services and programs that will improve the oral health of the people of Maryland or any other state, someone has to have the nerve to speak up to people who have the power to take action when the time is right.

Very few people can control the rightness of the time for action, so it is important for state dental programs to maintain a state of readiness by doing the work to provide data that will help support the need for action. They must take whatever role is necessary to assure that they have plans that will provide a roadmap for the types of action that make sense because they are based in scientific evidence and are most likely to make a real difference. Therefore, the academic and research communities should provide that scientific base and participate in state oral health coalitions. State dental programs must have in place the relationships, both internal to their organizations and external to their broad array of partners, which are needed to accomplish substantial and lasting change.

The Maryland Summit was designed to learn from others. But the truth is that there is much that other states can learn from Maryland. Given Maryland's track record, I do not believe that the public oral health community in this state lacks chutzpah nor do I suspect that this community does not appreciate the value of connections and continually seeking to nurture current ones and cultivate new ones. Isman *et al*. have given good practical advice for continuing to do the hard work that is only periodically rewarded. I encourage Maryland and other states to use that advice; increase the odds of success for when the time, once again, is right; and be persistent.

Conflict of interest

The author has declared to conflict of interest relevant to the submitted work.

Doing more with less: the challenge facing state oral health efforts

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As they recover from the Great Recession, states are still coping with serious fiscal problems. Setting budget priorities gives state governments a good reason to review their oral health programs, preserving cost-effective initiatives that focus on prevention and save taxpayers money.

In 2006, Americans made more than 330,000 trips to hospital emergency rooms (ERs) primarily due to tooth decay or other preventable dental problems. These visits cost nearly $110 million (1). For states, the financial penalty is severe. A study of Medicaid enrollees found that in-patient ER treatment for dental problems cost nearly 10 times more per patient than preventive care in a dentist's office (2).[1]

Of course, better prevention requires better access, and roughly 83 million Americans face barriers to dental care (3). Recent events, including the tooth infection that killed an Ohio man in September, remind us how far we must go to build a system that offers access for everyone (4). Though states' resources are scarce, critical needs remain. Simply put, we have to do more with less.

Prioritizing prevention can make the most of limited resources. State oral health programs are the lynchpin for prevention efforts. As Isman *et al*. find, these programs play a crucial role in gathering data, planning interventions, coordinating resources, and ensuring evidence-based responses. To highlight these programs, the Pew Children's Dental Campaign has released 50-state reports that include three benchmarks related to key dental programs: access to sealant programs, prevalence of fluoridated water, and participation in national data surveillance systems.

While oral health stakeholders agree on the need for prevention in theory, in practice more must be done to eliminate barriers that are codified in laws or rules. For example, 21 states maintain outdated laws requiring a dentist's exam before hygienists can place sealants on children's teeth. Extensive evidence contradicts the need for this hurdle (5-7).[2] Furthermore, 23 states fail to provide fluoridated water to at least 75 percent of their residents whose homes are connected to public water systems (8).

Besides changing outdated policies, states will need to be creative in finding new resources. Partnerships with foundations and corporations can help enhance capacity. A 2008 analysis revealed that foundation grants for oral health represented only 0.34 percent of total foundation giving (9). While small, this support is growing. By engaging these organizations, state dental programs can increase funding for critical services.

Infrastructure – having both the capacity to carry out programs and evaluate progress – is essential. This was recognized by the Institute of Medicine, whose July 2011 report recommended that all 50 states receive oral health infrastructure grants from the Centers for Disease Control and Prevention; currently, only 20 states draw such funding (10). Similarly, the Affordable Care Act contained a provision, not yet funded, to provide all states with these grants. States with infrastructure grants and seasoned public health leadership are better positioned to address oral health disparities than states without them. Implementing these proposals will help states confront the challenges of doing more with less.

[1] A study found that the mean Medicaid reimbursement for in-patient ER treatment for dental problems was $6,498, compared with the mean Medicaid reimbursement of preventive care in a dentist's office which was $660.

[2] Systematic reviews by the Centers for Disease Control and the American Dental Association indicate that it is appropriate to seal teeth that have early non-cavitated lesions, and that visual assessments are sufficient to determine whether non-cavitated lesions or cavitated lesions are present. Accreditation standards for dental hygiene training programs include standard 2-11, relating to education of dental hygiene students on dental-specific anatomy and pathology, with the intent of providing "the student with knowledge of oral health and disease as a basis for assuming responsibility for assessing, planning and implementing preventive and therapeutic services."

Conflict of interest

The author declares no conflict of interest.

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