children's dental health project

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SGR Team, NIH/NIDCR
31 Center Drive, Room 5B55
Bethesda, MD 20892

Dear Surgeon General's Report Team:

The Children's Dental Health Project (CDHP) appreciates having had the opportunity to participate in the initial Surgeon General's Listening Session on Oral Health, and we are pleased to offer comments on the upcoming Surgeon General's Report on Oral Health. As the national nonprofit policy organization with the vision that no family should be held back from their dreams because of dental disease, we applaud the Surgeon General's emphasis on oral health as a key issue in improving the nation's overall well-being. As the Surgeon General himself suggested during the November 2018 Listening Session, despite significant progress in expanding access to dental coverage in recent years, poor oral health remains a driver of inequity in our country. Moreover, many of the themes highlighted in the 2000 Surgeon General's Report on Oral Health in America continue to be relevant, pointing to the need for significant policy change at both the national and state level.

Oral Health Across the Lifespan

CDHP strongly supports the Report Team's proposed theme of oral health across the lifespan and encourages a comprehensive look at risk factors, protective factors, and population-specific outcomes as they relate to quality of life and daily function. We do, however, urge the Report Team to consider the prevalence and severity of chronic conditions like dental caries more broadly than untreated disease. This is especially important for children and adolescents as overall disease prevalence and severity remains an issue of equity, even as rates of untreated decay have decreased. Given advances in prevention and disease management (such as remineralization and caries arrest agents like silver diamine fluoride), current measures of disease prevalence and untreated disease fall short of describing how disease severity is influenced by clinical interventions. For example, an unfilled but arrested carious lesion may still be counted as untreated decay during an in-mouth examination for the National Health and Nutrition Examination Survey (NHANES). Furthermore, both public and private coverage programs are required to report on basic measures of utilization (e.g., annual dental visits or preventive dental services) but these programs do not measure changes in disease severity as a result of clinical interventions. In general, we encourage the Report Team to call for the adoption of more meaningful oral health measures that better reflect oral health outcomes, disease severity, and quality of life across public health and care delivery programs.[i]

In examining the role of parents in promoting the oral health of their children, we encourage the Report Team to consider how family risk factors, parent's access to coverage and care, and dyadic treatment approaches may influence a child's oral health outcomes. Given the strong connection between parent and child oral health[ii], the Report Team should consider how benefits and care protocols could be modified to better address the oral health of parents and children at the same time.[iii]

Of considerable importance is the role of adequate coverage for parents and working-age adults, including pregnant women—for whom dental coverage, especially in public programs like Medicaid, is a confusing and inconsistent patchwork. The importance of oral health care during pregnancy is well-recognized, even beyond the oral health community. In fact, the American College of Obstetricians and Gynecologists has concluded and reaffirmed that "ample evidence shows that oral health care during pregnancy is safe and should be recommended to improve the oral and general health of the woman."[iv] Unfortunately, despite multiple federally-funded efforts to improve access, many pregnant women are unable to access the care they need, even when they have dental coverage and are referred to care by their obstetrician or gynecologist.[v] Dental coverage is an optional benefit for pregnant women and adults in public programs like Medicaid; additionally, neither access to oral health care nor oral health outcomes are typically tracked for this population. We, therefore, encourage the Report Team to consider how changes to coverage and measurement policies could improve pregnant women's oral health.

Effect of Oral Health on the Community, Overall Well-Being, and the Economy

While rates of untreated tooth decay have declined among young children, dental caries remains the most common chronic condition of early childhood.[vi] Moreover, untreated dental disease continues to impact working-age adults[vii] and remains an issue of equity, disproportionately affecting people of color and low-wage families.[viii] However, too often the oral health community focuses its public messaging on the prevalence of disease and on oral health as an end unto itself despite the increasingly apparent connections between oral health and the socio-economic factors that drive overall health and well-being. Therefore, we applaud the Surgeon General and the Report Team for including the "Effect of Oral Health on the Community, Overall Wellbeing, and the Economy" as a prominent theme in the upcoming report.

As CDHP has highlighted in a recent fact sheet on family oral health[ix] and our comments on the Surgeon General's Call to Action on Community Health and Prosperity[x], the non-clinical impacts of oral health are far-reaching and significant. Poor oral health can: harm employability[xi] and earnings over the lifespan[xii]; impede children's school attendance and performance,[xiii] impact mental health and contribute to depressive conditions[xiv]; and indicate childhood trauma.[xv,xvi] We, therefore, encourage the Surgeon General and the Report Team to align their efforts on oral health with the Surgeon General's broader priorities on community health and prosperity. We also encourage the Report Team to fully consider how community level and non-clinical interventions and programs may address the needs of people for whom oral health is one of many barriers to success.

Oral Health Integration and Workforce

CDHP applauds the Report Team for establishing integration and workforce as a primary theme in the upcoming report. The 2000 Surgeon General's Report on Oral Health in America called for a concerted effort to integrate oral health effectively into overall health. Over the last two decades, there has been meaningful progress in incorporating basic oral health interventions into primary care for children. Pediatricians can be reimbursed for topical fluoride applications in in every state's Medicaid program, and the American Academy of Pediatrics emphasizes oral health risk assessment, fluoride treatments, and referral to dental care in their clinical guidelines. In addition, the Affordable Care Act (ACA) recognized the importance of oral health by requiring most private health plans to cover such services by primary care physicians without

cost-sharing.[xvii] While we would expect these policies to accelerate the integration of oral health into primary care for young children, only 11 percent of Medicaid-enrolled children aged 1-2 years received oral health services from non-dental providers in 2015.[xviii] This points to the need for policies and alternative payment mechanisms that better incentivize and track oral health care outside of the dental office, and emphasize a team-based approach to coordinating oral health care across medical and dental teams.[xix]

The importance of interdisciplinary approaches to oral health care and disease management is further underscored by the fact that dental disease shares common risk factors with other chronic conditions.[xx] However, the implementation of integrated care models and even basic care coordination across provider types is severely hindered by a lack of common coding and electronic health record systems for health and dental professionals. As such, we strongly urge the Report Team to emphasize the need for federal requirements and incentives aimed at integrating health information technology.

Moreover, because dental disease is influenced by social and behavioral factors in addition to clinical interventions, oral health inequities are likely to persist unless oral health is integrated into non-dental and non-clinical touchpoints for children and families.[xxi] As such, we encourage the Report Team to examine strategies to address oral health as part of more holistic approaches to improving social, economic, and overall well-being. For example, community health workers are well-positioned to assist families in addressing oral health behaviors and risk factors in concert with interventions aimed at ameliorating barriers to housing, access to food, employment, etc.[xxii] Oral health curricula and training materials for lay health workers have been developed by multiple entities but integration of this workforce into public programs likely requires changes to state and federal payment policies.

If we are to achieve the vision outlined in the 2000 Surgeon General's Report on Oral Health in America, significant policy change must take place. Otherwise, we may find ourselves 20 years in the future reflecting on the fact that separate and unequal systems of care continue to fail in meeting the needs of all people. Without policies that require change, our data collection and measurement priorities will fall short of describing the problem, our financing and care delivery paradigms will continue to emphasize treatment over prevention, oral health care will largely remain separate from overall health care, and oral health itself will continue to be viewed as supplemental rather than essential to well-being and prosperity. We, therefore, call on the Surgeon General and the Report Team to be bold in stating the need for structural change driven by public policy and be as explicit as possible in identifying both the barriers to progress and the policy levers necessary for our country to eliminate oral health as an obstacle to prosperity. We look forward to serving as a resource to the Report Team as they author their respective sections. Please contact Colin Reusch with any questions or request for information at: creusch@cdhp.org or (202) 417-3595

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