

# Maryland Oral Health Plan

2011-2015



Maryland Dental  
Action Coalition

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# Maryland Dental Action Coalition

Access to Oral Health Care for All Marylanders

Dear Colleagues,

The Maryland Dental Action Coalition (MDAC) is pleased to present the 5-year (2011–2015) state plan to promote the oral health of all Marylanders—children, adolescents, adults, and older adults. The state oral health plan addresses Maryland’s most critical oral health needs and capitalizes on available data and resources.

Development of the plan involved many key individuals working in state and local government agencies, academic institutions, professional dental organizations, private practice, community-based programs, the insurance industry, and advocacy groups, as well as in other organizations. To make the process effective and efficient, yet also comprehensive, three groups were formed—a small workgroup (planning team), a 20-person committee (writing team), and a large stakeholder group (review team). The small workgroup coordinated the development of the plan; the committee drafted components of the plan; and the large stakeholder group, with representatives from a wide range of organizations throughout Maryland, provided input on drafts. Throughout the process, MDAC members also offered guidance and input on drafts. (See Contributors to the Maryland Oral Health Plan.)

No plan is self-executing. The goals, objectives, and activities enumerated in this document will be the basis for a work plan with responsibilities, timelines, and expected outcomes to be determined. The Maryland Oral Health Plan (MOHP) is a living document that will be revisited and modified as implementation proceeds.

MDAC is committed to ensuring that the recommended activities are implemented and that the goals and objectives are achieved. As this plan moves forward, we invite you to participate in the process to improve the oral health of all Marylanders. Your involvement can help turn this plan into a reality!

In closing, we wish to extend our appreciation to those who volunteered their valuable time, knowledge, and expertise to help produce the MOHP. Thank you for your fabulous work!

Sincerely,

Penny Anderson, M.S.W.  
MDAC Executive Director



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# Executive Summary

We have made great strides in improving oral health in Maryland over the last decade, but there is much more to be done, especially to protect the oral health of our most vulnerable populations.

Oral health is a critical component of overall health, and poor oral health has been linked to a number of systemic diseases. Most common oral diseases can be prevented through a combination of individual, community, and professional strategies.<sup>1</sup> Prevention and early intervention work! Oral health professionals and other health professionals; staff working in child care, schools, and nursing homes; insurers; and others can do a great deal to improve oral health. Encouraging people to brush their teeth with fluoridated toothpaste, floss, avoid frequent exposure to foods and beverages high in sugar, visit the dentist, receive dental sealants and fluoride varnish applications, and wear oral and facial safety equipment when engaging in sports and other physical activities will help improve the oral health of all Marylanders. These actions are the focus of the Maryland Oral Health Plan (MOHP).

## Oral Health Status in Maryland

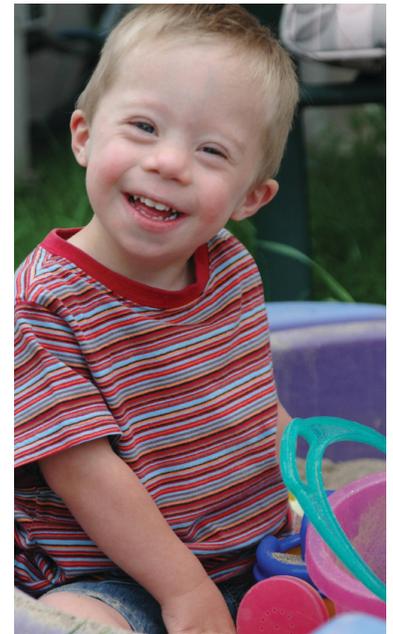
The report *The Burden of Oral Diseases in Maryland* identifies oral health gaps in several populations within the state, including:<sup>2</sup>

- Children and adults with special health care needs.
- Children and adults of low socioeconomic status.
- Children and adolescents enrolled in Medicaid.
- Certain racial and ethnic groups.

Highlights of the report include:

- Among schoolchildren in third grade, 29.7 percent have untreated dental caries, with a substantially higher prevalence among Hispanic schoolchildren (42 percent).<sup>3</sup>
- In Maryland, 93.8 percent of residents live in communities with fluoridated water.<sup>4</sup>
- In 47.3 percent of cases, oral cancer is diagnosed at the regional stage (i.e., cancer that has spread beyond the primary site to nearby lymph nodes, organs, or tissues).<sup>5</sup>
- Whites have a higher incidence of oral cancer than blacks (9.41/100,000 vs. 7.6/100,000), whereas blacks have a higher mortality rate than whites (3.7/100,000 vs. 2.6/100,000).<sup>5</sup>
- Lack of teeth cleaning before or during pregnancy is more prevalent among Hispanic women (42 percent), black women (33 percent), and Asian women (25 percent), than among non-Hispanic white women (17 percent).<sup>6</sup>

In 2008, approximately 57 percent of adults reported that they had never had any permanent teeth extracted, up from 49.3 percent in 1999. In addition, in 2008, approximately 12.4 percent of adults ages 65 and older reported having all their teeth extracted, down from 25.5 percent in 1999, indicating that more adults are retaining their teeth.<sup>7</sup>



In 2005–2006, the Department of Health and Mental Hygiene, Office of Oral Health, and the University of Maryland Dental School screened 1,292 schoolchildren in kindergarten and third grade to obtain information about their oral health status. The resulting survey reported the following findings:<sup>3</sup>

- Schoolchildren who resided on the Eastern Shore were more likely to have untreated dental caries than those who resided in Southern or Western Maryland.
- Non-Hispanic white schoolchildren had a lower prevalence of untreated dental caries than non-white schoolchildren.
- The prevalence of untreated dental caries was lower among schoolchildren whose parents were college graduates than among those whose parents had not graduated from college.
- Among schoolchildren in kindergarten, 7.5 percent had dental sealants, and among those in third grade, 42.4 percent had sealants.
- Non-Hispanic black schoolchildren were less likely to have at least one dental sealant than non-Hispanic white schoolchildren.
- Schoolchildren who resided on the Eastern Shore and in Central Baltimore were less likely to have dental sealants than those with similar demographics who resided in Western Maryland or Central Washington, DC.
- Dental sealant prevalence was lower among schoolchildren eligible for a free or reduced meal program than among schoolchildren not eligible for such a program.



### **Development of the Maryland Oral Health Plan**

In 2007, the Dental Action Committee (DAC), a statewide committee, was convened by John M. Colmers, Secretary of the Maryland Department of Health and Mental Hygiene (DHMH) to develop recommendations to improve access to oral health care for vulnerable (disadvantaged and/or underinsured) children. Since that time, DHMH's Office of Oral Health, the Maryland Medicaid Program, and many public- and private-sector partners have made great strides in achieving nearly all of the DAC recommendations.

In 2010, DAC transitioned into the Maryland Dental Action Coalition (MDAC), an independent, broad-based partnership of individuals and organizations whose charge is to monitor progress on DAC's recommendations and to expand access to oral health care for all Marylanders. To develop a multifaceted strategic plan to promote the oral health of all Marylanders (children, adolescents, adults, and older adults), MDAC initiated the development of a 5-year state oral health plan.

To make the process effective and efficient, three groups were formed—a small workgroup (planning team), a 20-person committee (writing team), and a large stakeholder group (review team). The workgroup coordinated the development of the plan; the committee drafted components of the plan; and the stakeholder group, with representatives from a wide range of organizations throughout Maryland, provided input on drafts. Throughout the process, MDAC members also offered guidance and input.

The first step in the process was conducting a comprehensive review of the current oral health status of Marylanders and of available data and resources. This activity led to the identification of three key focus areas: (1) access to oral health care, (2) oral disease and injury prevention, and (3) oral health literacy and education. Based on this information, the group developed a vision statement and identified essential goals for each focus area. The vision statements and goals follow.

### Access to Oral Health Care

*Vision Statement:* By 2015, Maryland will be a leader in access to oral health services. All Marylanders—children, adolescents, adults, and older adults, including those with special health care needs—will be able to locate and access a local oral health professional who will see them in a timely manner. An integrated partnership of general health professionals and oral health professionals and private, nonprofit, and government organizations will provide a seamless system of oral health care. Primary care health professionals, understanding the importance of oral health and its relationship with overall health, will participate in early identification and assessment of individuals' oral health needs.

- Goal 1:* Ensure continuously accessible, coordinated, affordable, and effective oral health care (dental home) for all Marylanders through an integrated state oral health and health care system.
- Goal 2:* Build an optimal oral health work force to ensure the availability of oral health services for all Marylanders.
- Goal 3:* Strengthen the integration of oral health care and overall health care.

### Oral Disease and Injury Prevention

*Vision Statement:* By 2015, an oral-disease- and injury-prevention system will have been developed and implemented. Through an integrated partnership of private, nonprofit, and government stakeholders, oral-disease- and injury-prevention programs will become standardized, institutionalized, and commonplace throughout Maryland. Evidence-based strategies will target services to populations at risk for oral disease and injury, ensuring that preventive services are accessible to all. This system will provide standards drawn from best practices in oral disease and injury prevention.

- Goal 1:* Regularly assess the oral health status of all Marylanders, including those living in nursing homes, assisted-living facilities, group homes, and shelters; those who are homeless; those with disabilities; and those who are migrants or immigrants.
- Goal 2:* Increase the use and adoption of best practices to prevent oral disease and injury in all settings, including public health and private practice.
- Goal 3:* Promote the public's awareness of risk factors for oral cancer, its symptoms, and ways to prevent it.
- Goal 4:* Ensure that communities have access to oral-disease- and injury-prevention programs.

#### **Lack of Oral Health Care for Adults with Low Incomes**

There is a severe shortage of oral health care for adults with low incomes, who typically are ineligible for publicly funded programs. At one public health clinic, adults who need extractions frequently begin standing in line at 4:00 a.m. waiting for the clinic to open at 7:00 a.m. Because the demand for service exceeds the clinic's capacity, many who stand in line are turned away without care.

## Oral Health Literacy and Education

*Vision Statement:* By 2015, the distinction between oral health and general health will begin to blur. Soon afterwards, oral health care will no longer be seen as ancillary but instead as a specialty within general health, much like cardiology, neurology, or internal medicine. Health professionals will refer individuals to dentists, as they would to any other specialists. Academic and continuing education courses will provide health care students and health professionals with consistent oral health messages to foster clear communication with the public. Individuals will begin to perceive oral health care as basic health care, understand its importance, and appreciate the benefits of good oral health. They will also begin to obtain, process, and understand basic information needed to access oral health care and to make appropriate decisions.

*Goal 1:* Enhance individuals' awareness of the relationship between oral health and general health and wellness to empower them to adopt good oral health behaviors supported by evidence-based practice.

*Goal 2:* Enhance individuals' ability to navigate the oral health care system and to establish dental homes.

*Goal 3:* Promote primary care health professionals' and specialists' awareness and knowledge of the importance of oral health interventions for medically compromised individuals.

*Goal 4:* Enhance oral health professionals' ability to work with diverse populations.



To achieve the vision and to make the goals a reality, meaningful objectives and practical but innovative activities were identified for each key focus area. In addition, a logic model was developed that delineates the social change necessary to establish comprehensive, continuously accessible, family-centered, coordinated, compassionate, and culturally effective oral health care (i.e., a dental home) for all Marylanders, the overarching goal of the MOHP.

Many individuals working in state and local government agencies, academic institutions, professional dental organizations, private practice, community-based programs, the insurance industry, and advocacy groups, as well as in other organizations, were instrumental in the development of the plan (see Contributors to the Maryland Oral Health Plan).

### **Implementation of the Maryland Oral Health Plan**

With the release of the plan, MDAC moves into the implementation phase with the goals, objectives, and activities providing the basis for a collaborative workplan that will identify measurable outcomes and those responsible for achieving them, as well as the timeline for implementation. The MOHP is intended to be a living document that will be reviewed at least annually and modified as needed as implementation proceeds.

MDAC is optimistic that the release of the plan marks not the end of thoughtful and creative discussion by committed individuals but the beginning of collaborative action to improve the oral health of all Marylanders. MDAC takes inspiration from Helen Keller, who once said “alone we can do so little; together we can do so much!”

# Contributors to the Maryland Oral Health Plan

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## Overview of the Maryland Dental Action Coalition

The Maryland Dental Action Coalition (MDAC) is a statewide coalition of individuals and organizations dedicated to improving the oral health of all Marylanders through increased prevention, education, advocacy, and access to oral health care. Participants include dentists, dental hygienists, and other health professionals working in the public and private sectors; representatives from government agencies and educational institutions; advocates; funders; and others who are passionate about MDAC's mission.

The coalition is built on the work of the Dental Action Committee (DAC), which was established in 2007 by John Colmers, Secretary of the Maryland Department of Health and Mental Hygiene (DHMH), in response to a lack of access to oral health care for vulnerable (disadvantaged and/or underinsured) children. The problem of insufficient access became glaringly apparent with the untimely death of Deamonte Driver that resulted from an untreated tooth infection that spread to his brain.

Secretary Colmers charged DAC to develop recommendations addressing the following:

- Medicaid reimbursements and alternative models
- Provider participation, capacity, and scope of practice
- Public health strategies
- Oral health education and outreach to parents and other caregivers

In September 2007, DAC put forth seven major recommendations.<sup>8</sup> Since that time, DHMH's Office of Oral Health, the Maryland Medicaid Program, and many public- and private-sector partners have made great strides in achieving nearly all the recommendations. As a result of these and other efforts, Maryland has become a national model for providing access to oral health care for vulnerable children.

Building on the momentum of DAC's successes, DHMH, the Centers for Disease Control and Prevention, and the DentaQuest Foundation supported the establishment of MDAC, an independent broad network of stakeholders whose charge is to monitor the continued progress of DAC's recommendations and to expand access to oral health care for all Marylanders. Since April 15, 2010, when the coalition filed its articles of incorporation, MDAC has been working toward these goals, with the first step being the development of a 5-year state oral health plan for Maryland.



# Overview of Oral Health in Maryland

## Oral Health Status

The report *The Burden of Oral Diseases in Maryland* identifies oral health gaps in several populations within the state, including:<sup>2</sup>

- Children and adults with special health care needs.
- Children and adults of low socioeconomic status.
- Children and adolescents enrolled in Medicaid.
- Certain racial and ethnic groups.

Highlights of the report include the following:

- Among schoolchildren in third grade, 29.7 percent have untreated dental caries, with a substantially higher prevalence among Hispanic schoolchildren (42 percent).<sup>3</sup>
- In Maryland, 93.8 percent of residents live in communities with fluoridated water.<sup>4</sup>
- In 47.3 percent of cases, oral cancer is diagnosed at the regional stage (i.e., cancer that has spread beyond the primary site to nearby lymph nodes, organs, or tissues).<sup>5</sup>
- Whites have a higher incidence of oral cancer than blacks (9.41/100,000 vs. 7.6/100,000), whereas blacks have a higher mortality rate than whites (3.7/100,000 vs. 2.6/100,000).<sup>5</sup>
- Lack of teeth cleaning before or during pregnancy is more prevalent among Hispanic women (42 percent), black women (33 percent), and Asian women (25 percent), than among non-Hispanic white women (17 percent).<sup>6</sup>

In 2008, approximately 57 percent of adults reported that they had never had any permanent teeth extracted, up from 49.3 percent in 1999. In addition, in 2008, approximately 12.4 percent of adults ages 65 and older reported having all their teeth extracted, down from 25.5 percent in 1999, indicating that more adults are retaining their teeth.<sup>7</sup>

In 2005–2006, Maryland’s Department of Health and Mental Hygiene, Office of Oral Health (OOH), and the University of Maryland Dental School screened 1,292 schoolchildren in kindergarten and third grade to obtain information about their oral health status. The resulting survey reported the following findings:<sup>3</sup>

- Schoolchildren who resided on the Eastern Shore were more likely to have untreated dental caries than those who resided in Southern or Western Maryland.
- Non-Hispanic white schoolchildren had a lower prevalence of untreated dental caries than non-white schoolchildren.
- The prevalence of untreated dental caries was lower among schoolchildren whose parents were college graduates than among those whose parents had not graduated from college.
- Among schoolchildren in kindergarten, 7.5 percent had dental sealants, and among those in third grade, 42.4 percent had sealants.



- Non-Hispanic black schoolchildren were less likely to have at least one dental sealant than non-Hispanic white schoolchildren.
- Schoolchildren who resided on the Eastern Shore and in Central Baltimore were less likely to have dental sealants than those with similar demographics who resided in Western Maryland or Central Washington, DC.
- Dental sealant prevalence was lower among schoolchildren eligible for a free or reduced meal program than among schoolchildren not eligible for such a program.

## **Access to Oral Health Care**

### Local Health Departments

In September 2007, only 12 of the 24 jurisdictions (23 counties and Baltimore City) had local health departments with clinical oral health services available on site. Of these, only 9 provided oral health care to Medicaid recipients. The Dental Action Committee (DAC) focused attention on these issues. This resulted in the 2007 Oral Health Safety Net legislation (SB 181/ HB 30), which directed OOH to expand the oral health infrastructure through development and enhancement of local oral health programs. Since that time, efforts have been made to strengthen the oral health safety net in every jurisdiction, with a particular emphasis on counties without public oral health services.<sup>9</sup>

Each of the 24 local health departments throughout Maryland received a grant from OOH to provide oral health services to children and adults. These services include clinical services, dental sealants, oral cancer screening, and fluoride treatments.

### Federally Qualified Health Centers

In Maryland, there are 16 federally qualified health centers (FQHCs) with 95 service delivery sites.<sup>10</sup> About half of FQHCs provide oral health services to individuals enrolled in Medicaid, but these programs exist only in limited areas of the state. For instance, on the Eastern Shore, nine counties are served by only two FQHCs. The majority of the state's FQHCs are located central Maryland, with one-third of the centers located in Baltimore City.

#### **Lack of Dental Insurance for Adults with Low Incomes**

Many adults with low incomes do not have dental insurance and are unable to access regular and preventive oral health care to help maintain their oral health. Medicare provides medical coverage but not dental coverage. Medicaid provides dental coverage for only a small portion of adults enrolled in the program. Many are suffering, including an individual who hadn't had his teeth cleaned in 40 years, another who needed dentures and wasn't able to chew food, and one more who lost his job and his dental insurance and had to have 20 teeth extracted.

### Comprehensive and Emergency Oral Health Care

The University of Maryland Dental School is the largest provider in the state of comprehensive and emergency oral health care for people of all ages, the underserved, and the disadvantaged. Each year, the dental school serves nearly 35,000 people through more than 122,000 dental visits. In addition, the dental school is the largest provider of oral health care for those with HIV and for children eligible for Medicaid. The Special Patient Clinic provides specialized care for individuals who are medically challenged.<sup>11</sup>

### Education Programs

The University of Maryland provides education programs in dentistry and dental hygiene as well as advanced dental education programs in endodontics, oral and maxillofacial pathology, oral maxillofacial surgery, orthodontics, dentofacial orthopedics, pediatric dentistry, general dentistry, periodontics, and prosthodontics.<sup>11</sup>

Maryland has five dental hygiene programs. They are Allegany College of Maryland, Baltimore City Community College, the Community College of Baltimore County, Fortis College, and the University of Maryland Dental School. There are many dental assistant programs in the state. Programs include All-State Career, Allegany Community College, Ann Arundel Community College, Carroll Community College, Center for Applied Technology South, Chesapeake College, DATS, Fortis College, Hagerstown Community College, Howard Community College, James Forrest Career and Technology Center, the Maryland State Dental Association, Medix, Neibauer Dental Care, and the Southern Maryland Dental Society.



### Dental Work Force

In 2010, there were 4,149 licensed dentists in Maryland. Eighty percent were general dentists, 5 percent were orthodontists, 4 percent were oral surgeons, 3 percent were pediatric dentists, and 3 percent were endodontists. About 75 percent of dentists are concentrated in six jurisdictions and are centrally located in urban areas. These six jurisdictions are the most populated in the state and include 71 percent of the state's population.<sup>12</sup> Dental Health Professional Shortage Areas (HPSAs) are designated by the Health Resources and Services Administration as having shortages of dental providers and may be geographical (county or service area), demographic (population with low income), or institutional (comprehensive health center, federally qualified health center, or other public facility).<sup>13</sup>

In 2010, there were 2,615 licensed dental hygienists in Maryland. About 74 percent of hygienists practice in eight counties. Much like dentists, the majority of them practice in urban areas.<sup>12</sup>

### Medicaid

In the United States, 51 percent of Medicaid recipients are children. According to the Kaiser Family Foundation, approximately 63 percent of Maryland's Medicaid recipients are children.<sup>14</sup>

According to Maryland's 2010 Annual Oral Health Legislative Report, in 2008, less than 19 percent of licensed dentists participated in the Maryland Medicaid Program.<sup>15</sup> However, as of December 2010, approximately 25 percent of dentists were Medicaid providers.<sup>12</sup>

## **Oral Disease and Injury Prevention**

### Dental Visits

Regular dental visits are important in reducing the burden of oral disease. In 2005–2006, 83.1 percent of parents of students in kindergarten and third grade reported that their child visited a dentist within the last 12 months, 31.1 percent reported diagnosed dental caries in the last 12 months, and 25.8 percent reported that their child received treatment within the same time frame.<sup>3</sup>

In 2007, 79.1 percent of parents reported that their child received preventive oral health care in the past 12 months, slightly higher than the national average of 78.4 percent.<sup>16</sup>

In 2008, 72.6 percent of adults reported that they had visited a dentist or a dental clinic within the past year. Forty-three percent of adults reported having one or more permanent teeth extracted some time in the past, and 12.4 percent of adults ages 65 and older reported having had all their teeth extracted.<sup>7</sup>

### Children with Special Health Care Needs

In 2009–2010, the Center for Maternal and Child Health and The Parents' Place of Maryland conducted a statewide survey of parents of children with special health care needs to learn about their views, perceptions, and experiences with using the health care delivery system. They found that 92 percent of parents reported that their child's teeth were brushed at least once a day. In addition, when parents were asked, "how long has it been since you or your child last went to a dentist for a check-up," 65 percent reported 6 months or less, 19 percent reported more than 6 months but not more than a year, and 16 percent reported more than a year.<sup>17</sup>

### Pregnant Women

Based on PRAMS 2004–2007 data, 66.5 percent of women reported that they had their teeth cleaned before their recent pregnancy, and 37.8 percent of women reported that they had their teeth cleaned during their recent pregnancy. When looking at disparities by race and ethnicity among women, lack of teeth cleaning before or during this period was more prevalent among Hispanic women (42 percent), black women (33 percent), and Asian women (25 percent), than among non-Hispanic white women (17 percent). Women with less than a high school education (44 percent) were more likely to not have had their teeth cleaned than those with a high school education or higher (16 percent). Many unhealthy behaviors and factors, such as unintended pregnancy, late initiation of prenatal care, lack of vitamin intake, job loss, unpaid bills, and depression were significantly more prevalent among women who did not have their teeth cleaned before or during pregnancy than among women who did.<sup>6</sup>



### Dental Sealants

The *Healthy People 2010* national health objective was to increase dental sealant utilization to 50 percent.<sup>18</sup> Primary data collection every 5 years reported that 42.4 percent of students in third grade had dental sealants.<sup>3</sup>

### Water Fluoridation

In 2009, 93.8 percent of the population on public water supplies were served by supplemental and naturally fluoridated water systems.<sup>4</sup> Maryland has surpassed the *Healthy People 2010* national health objective target of 75 percent of the U.S. population served by community water systems with optimally fluoridated water.<sup>18</sup>

### Fluoride Varnish

OOH, in collaboration with the University of Maryland Dental School and the National Maternal and Child Oral Health Resource Center, developed the training program *Maryland's Mouths Matter: Fluoride Varnish and Oral Health Screening Program for Kids* (<http://www.fha.maryland.gov/oralhealth>) in an effort to collaborate with licensed Early and Periodic Screening, Diagnosis and Treatment (EPSDT) medical providers, including pediatricians, family physicians, and nurse practitioners, to address children's oral health needs.<sup>19</sup>

EPSDT medical providers who successfully complete the training program are reimbursed by the Maryland Medicaid Program for fluoride varnish application on children ages 9 months to 36 months as part of their routine well-child visits. From July 1, 2009, through December 31, 2010, the Maryland Medicaid Program reimbursed EPSDT medical providers for 22,182 fluoride varnish applications.<sup>20</sup>

### Tobacco

Tobacco use is believed responsible for more than 90 percent of oral cancers among men and 60 percent among women and is responsible for over 90 percent of oral-cancer-related deaths in males.<sup>21</sup> Evidence also indicates that tobacco use is one of the most significant risk factors in the development and progression of periodontal disease.<sup>22</sup> Tobacco use slows the healing process and complicates oral treatment results. This problem is not limited to cigarette users; in addition to being a causative agent for oral cancer, smokeless tobacco can cause gum recession and increase the chance of tooth loss. There is a 50 percent risk reduction after 3 to 5 years for oral and pharyngeal cancers in those individuals who stop smoking or reduce their exposure to smoke.<sup>23</sup>

#### **Lack of Preventable Oral Health Care**

Pain and suffering from oral disease could be reduced if preventive oral health services were available to all adults in Maryland. A woman called a dental office in tears. She was in terrible pain because she needed an extraction but could not afford to pay for care, and the pain was so bad that she had thought about ending her life. Although the dentist performed the extraction at no charge, such extreme treatment would not have been necessary if she had been identified early as being at high risk for disease and had received preventive services.

Maryland BRFSS 2008 data indicate that:<sup>7</sup>

- 14.9 percent of adults were current smokers (i.e., smoked every day or some days).
- 10.6 percent of adults smoked every day.
- 4.3 percent of adults smoked some days.
- 24.2 percent of adults were former smokers.

Based on Maryland PRAMS 2008 data on women who had a recent live birth,<sup>24</sup>

- 19.1 percent of women smoked 3 months before getting pregnant.
- 14.1 percent of mothers smoked.
- 10.9 percent of women smoked during the last 3 months of pregnancy.
- Of women who smoked, 43.7 percent quit during their pregnancy.

Mothers who did not quit smoking during their pregnancy had a greater chance of having a low-birthweight infant (< 2,500 grams) than those who quit smoking during pregnancy.<sup>24</sup>

### Oral Cancer

Nationally, Maryland ranked 25th in oral cancer mortality rate during 2001–2005.<sup>25</sup>

In 2007, 572 newly diagnosed cases of oral cavity and pharynx cancer (oral cancer) were reported. The annual age-adjusted incidence rate for oral cancers was 9.6 per 100,000, which is less than the national rate of 10.3 per 100,000. In addition, 27.3 percent of oral cancers were diagnosed at the localized stage (i.e., cancer is limited to the organ in which it began), 47.3 percent were diagnosed at a regional stage (i.e., cancer has spread beyond the primary site to nearby lymph nodes, organs, or tissues), and 17 percent were diagnosed at the distant stage. Because oral cancer has a better prognosis when diagnosed at the localized stage, diagnosis at a regional or distant stage contributes to a lower survival rate.<sup>5</sup>

The oral cancer mortality rate has significantly decreased in the past 10 years. According to the Centers for Disease Control and Prevention, Maryland ranked 20th among all states in 2002–2006, compared to 8th in 1997–2001. A decline in the oral cancer mortality rate for black males since 1999 has contributed to the improved overall oral cancer mortality rate.<sup>26</sup>

In 2006, there were 158 deaths from oral cancer in Maryland. Mortality rates for oral cancer show an overall slight downward trend. When compared by race and gender, males consistently have higher mortality rates than females. Historically, black males have higher mortality rates than white males, although the gap between rates for white and black males has decreased.<sup>25</sup>

When cancer is found at an early stage, treatment is easier and usually less invasive, with a higher chance of success. A *Healthy People 2010* national health objective was to increase the proportion of adults ages 40 and older who, in the past 12 months, reported having had an examination to detect oral and pharyngeal cancers detected at the earliest stage.<sup>18</sup> *The Maryland Cancer Survey, 2008* reported that 40 percent of adults ages 40 and older responded that they had an oral cancer



examination within the past 12 months, which is more than the *Healthy People 2010* national health objective target of 20 percent.<sup>27</sup> Although Maryland compares favorably to the United States as a whole, ideally, cancer examinations at dental appointments should be routine. It appears from research that cancer examinations may not be conducted routinely.

### Injury

Injuries to the head, face, and teeth are common. They range in severity from mild to deadly. Although injuries have a major impact on oral health, data on injury incidence and severity are limited. Most information about injuries pertains only to relatively severe ones, typically those resulting from falls, assaults, sports injuries, and motor vehicle collisions that involve a visit to the emergency department.

Oral injuries also occur as a result of physical abuse. Of all physical abuse cases that take place in the United States, 65 to 75 percent involve injuries to the head and neck region.<sup>1</sup> Maryland has a higher rate of child abuse than the national average, with an abuse rate of 14.4 per 1,000 children, compared to a rate of 12.4 per 1,000 children in the United States as a whole.<sup>28</sup> Oral health professionals, among others, are mandated by state law to report suspected cases of child abuse and neglect.<sup>29</sup> While oral health professionals are particularly well positioned to detect suspected cases of physical abuse and neglect, most do not screen for such problems.<sup>30</sup>

Clearly, more education is needed to encourage oral health professionals to screen for suspected cases of physical abuse and neglect. Maryland has a local chapter of P.A.N.D.A. (Prevent Abuse and Neglect through Dental Awareness), part of a national program designed to train oral professionals and other health professionals to recognize and respond to signs of abuse and neglect in individuals they care for. Founded in 2000, Maryland is part of Mid-Atlantic P.A.N.D.A., along with Delaware and the District of Columbia. Maryland-based organizations in Mid-Atlantic P.A.N.D.A. include the Maryland Dental Hygienists' Association, the Maryland Department of Health and Mental Hygiene, the Maryland State Dental Association, and the University of Maryland Dental School.<sup>31</sup>

### **Oral Health Literacy and Education**

Combatting oral disease in young children requires a multi-pronged approach such as that recommended by DAC. Low health literacy has been shown to contribute to low use of preventive practices and increased use of emergency services.<sup>32</sup>

#### Literacy Campaign

In response to the DAC recommendation to develop a unifying oral health messaging campaign, OOH has initiated a literacy campaign to better inform parents and caregivers from families with low incomes about the importance of oral health. The goal of the campaign is to decrease dental caries disparities in children, with special emphasis on families and other caregivers with low incomes who care for children ages 5 and under. The campaign's objectives are to improve access to oral health care, increase enrollment in the Medicaid dental program, and improve personal oral health behaviors.

This campaign aims to empower these groups to incorporate sound and evidence-based preventive measures, including appropriate use of fluoride, oral hygiene, and



dietary practices as well as appropriate oral health service utilization. The campaign also seeks to enable families to better navigate the oral-health-care-delivery system and to offer health professionals tools to help them communicate important oral health messages to the individuals they serve. It is expected that both health professionals and oral health professionals will play an enhanced role in interacting with their clients and with each other to make the oral-health-care-delivery system better coordinated and easier for consumers to use.

#### Focus Group Research

The Children's Dental Health Project, in collaboration with the University of Maryland School of Public Health, conducted three focus groups of pregnant women and mothers of children under age 2 from families with low incomes. The objective of the focus groups was to collect data on women's experiences, knowledge, practices, and opinions related to oral health, both for themselves and for their children. Additionally, women's reactions to various materials and messages, including those addressing vertical transmission, the age 1 dental visit, fluoride, and limiting sugars, were gathered.<sup>2</sup>

From discussions with focus group participants, the following implications were evident:

- Women need information about their child's oral health before they need to seek care for their child's oral health problems or pain.
- Health messages to women must be tailored to audiences with low literacy levels (e.g., short, very visual media).
- The continuum of care from childhood to adulthood must be addressed and promoted.
- Materials must address underlying causes that inhibit women from seeking care (e.g., fear of being separated from their child during the dental visit).
- Specific behaviors and misinformation about oral health must be addressed.

#### **Consequences of Lack of Oral Health Literacy**

A mother explained, "Before, I didn't understand how important it is to keep your mouth healthy. At my kid's dentist appointment, I thought the kids wouldn't have cavities, but they did! I learned more about how important it is to brush with fluoridated toothpaste, even for kids, and now I can do a better job taking care of my kid's teeth."



# Oral Health Plan for Maryland

## Access to Oral Health Care

*Vision Statement:* By 2015, Maryland will be a leader in access to oral health services. All Marylanders—children, adolescents, adults, and older adults, including those with special health care needs—will be able to locate and access a local oral health professional who will see them in a timely manner. An integrated partnership of general health and oral health professionals and private, nonprofit, and government organizations will provide a seamless system of oral health care. Primary care health professionals, understanding the importance of oral health and its relationship with overall health, will participate in early identification and assessment of individuals' oral health needs.

### GOAL 1

Ensure continuously accessible, coordinated, affordable, and effective oral health care (dental home) for all Marylanders through an integrated state oral health and health care system.

#### Objective 1

Decrease the incidence of uncompensated oral health care.

##### Activities

- Expand Medicaid dental coverage for vulnerable populations (e.g., postpartum women, Medicaid waiver populations, older adults, adults with special health care needs) at high risk for oral disease.
- Increase dental benefits (e.g., through private insurance, Medicare, health care reform) for vulnerable populations at high risk for oral disease.
- Provide dental coverage for care provided in hospitals.

#### Objective 2

Add or expand safety net dental programs that serve individuals, with emphasis on vulnerable populations, in clinical and non-clinical settings.

##### Activities

- Increase the number of safety net dental programs (e.g. school-based health centers, school-linked health centers, community-based health centers) located in communities providing oral health services to vulnerable populations.
- Increase the number of oral health professionals working in safety net dental programs.
- Provide transportation or mobile dental services (e.g., for individuals who are non-ambulatory and homebound or those living in isolated areas).
- Provide appropriate case-management services to improve access to oral health care.



### Objective 3

Increase the number of community service providers (e.g., health workers, case manager/patient navigators) that promote oral health.

#### Activity

- Develop and implement curricula for training community service providers.

## GOAL 2

Build an optimal oral health work force to ensure the availability of oral health services for all Marylanders.

### Objective 1

Identify gaps in the oral health work force, and develop strategies to address them.

#### Activities

- Conduct a needs assessment of the current oral health work force (e.g., number of oral health professionals, geographic area served, population served).
- Implement strategies to address gaps.

### Objective 2

Increase the number of dental and dental hygiene students, graduates, and professionals who serve vulnerable populations.

#### Activities

- Increase the number of scholarships and loan-forgiveness programs for dental and dental hygiene students and/or increase funding for such programs.
- Increase Medicaid dental reimbursement rates to the 50th percentile of the American Dental Association's South Atlantic region charges, indexed to inflation, for all dental codes.
- Evaluate the impact (e.g., utilization, patient satisfaction, network adequacy) of the single Medicaid dental administrator.
- Increase the number of hospital-based general practice residencies.
- Train general practice dentists to provide oral health care for young children and individuals with special health care needs.
- Encourage the use of dental hygienists to the full extent of their scope of practice in public health settings and long-term-care facilities.
- Establish a task force to evaluate alternative-care-delivery and finance models.
- Utilize public health dental hygienists to the extent of their scope of practice.
- Increase the number of community service and volunteer opportunities for oral health professionals, and encourage participation.

#### **Lack of Care for Individuals with Special Health Care Needs**

A 10-year old with special health care needs had dental coverage but was unable to receive care because he couldn't find a dentist. He had to wait 5 months for full upper and lower extractions. As a consequence of the delayed care, his overall health, well-being, and nutrition deteriorated, he was in chronic pain, and he was at risk for infection.

### GOAL 3

Strengthen the integration of oral health care and overall health care.

#### Objective 1

Foster clinical practice to promote integration of oral health and general health.

##### Activities

- Promote the use of electronic medical and dental records with links to the health information exchange.
- Integrate oral-health-related issues (e.g., counseling on medications that cause dry mouth) into medical histories.
- Integrate oral health screening and risk assessment into medical screenings.
- Allow medical continuing education credit to be applicable to dental continuing education credit and vice-versa.
- Establish dental current procedural codes to allow medical professionals to be reimbursed for oral-health-related procedures (e.g., fluoride varnish application, oral cancer screening).



#### Objective 2

Increase the number of primary care pediatric health professionals who conduct oral health screenings and risk assessments, apply fluoride varnish, provide education, and make referrals to oral health professionals for children and adolescents.

##### Activities

- Integrate oral health content into curricula for health professional schools and residency programs.
- Continue to train EPSDT medical providers and medical extenders using Maryland's Mouths Matter: Fluoride Varnish and Oral Health Screening Program for Kids to conduct oral health screenings and risk assessments, apply fluoride varnish, provide education, and make referrals for children age 9 months to 36 months to oral health professionals.
- Train primary care pediatric health professionals to perform oral health screenings, provide education, and make referrals to oral health professionals during routine medical visits.
- Ensure sufficient oral health referral sources.

#### Objective 3

Increase the number of primary care adult health professionals, including obstetricians and gynecologists, who provide oral health risk assessment and education and make referrals to oral health professionals for adults.

##### Activity

- Train primary care adult health professionals to perform oral health and oral cancer screenings, provide education, and make referrals to oral health professionals during routine medical visits.

#### Objective 4

Increase medical professionals' ability to recognize oral injuries and to make referrals to oral health professionals.

### Activities

- Assess medical professionals' knowledge about oral injury diagnosis and prevention.
- Train medical professionals on how to recognize oral injuries and provide referrals to oral health professionals.

## Oral Disease and Injury Prevention

*Vision Statement:* By 2015, an oral-disease and injury-prevention system will have been developed and implemented. Through an integrated partnership of private, nonprofit, and government stakeholders, oral-disease and injury-prevention programs will become standardized, institutionalized, and commonplace throughout Maryland. Evidence-based strategies will target services to populations at risk for oral disease and injury, ensuring that preventive services are accessible to all. This system will provide standards drawn from best practices in oral disease and injury prevention.

### GOAL 1

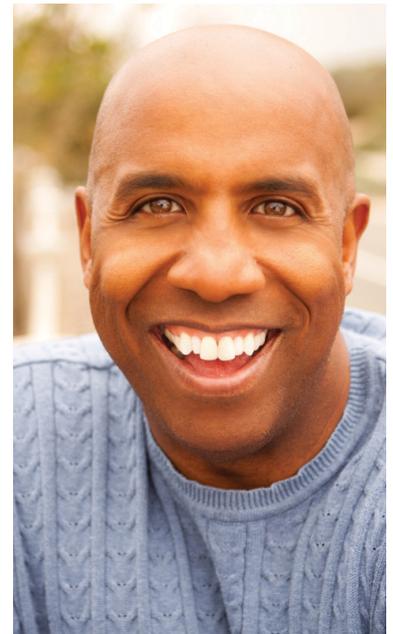
Regularly assess the oral health status of all Marylanders, including those living in nursing homes, assisted-living facilities, group homes, and shelters; those who are homeless; those with disabilities; and those who are migrants or immigrants.

#### Objective 1

Develop and maintain a comprehensive oral health surveillance system that identifies, investigates, and monitors oral health status, access points, needs, and services.

#### Activities

- Identify components of a comprehensive oral health surveillance system, including hospital emergency department use, for prevention and treatment of oral disease and injury.
- Develop a mechanism for gathering data on individuals' oral health status.
- Identify gaps in available data, and develop a method to address each gap, if feasible.
- Develop a comprehensive database for storing and retrieving oral health data.
- Conduct a statewide oral examination of children in kindergarten and in third grade attending public schools.
- Conduct oral health screenings of children, as recommended by the Dental Action Committee's Proposal for Dental Screenings in Public Schools.



### GOAL 2

Increase the use and adoption of best practices to prevent oral disease and injury in all settings, including public health and private practice.

#### Objective 1

Increase knowledge of best practices (e.g., evidence-based, proven effective) to prevent oral disease and injury, including those tailored to specific populations

(e.g., those of different ages, with different health conditions, and of different cultures) and to traditional and non-traditional settings.

**Activities**

- Identify a mechanism to assess best practices, and revise them periodically, as necessary.
- Develop a compendium of best practices.
- Develop a mechanism to educate the public and health professionals about the availability and use of best practices.
- Develop a plan to select and incorporate programs, where feasible.

**GOAL 3**

Promote the public’s awareness of risk factors for oral cancer, its symptoms, and ways to prevent it.

**Objective 1**

Support efforts to reduce the public’s use of tobacco products and alcohol.

**Activities**

- Identify and partner with successful tobacco-cessation programs to reduce tobacco use.
- Develop educational materials and messages for the public on the oral-health-related dangers of tobacco and alcohol use, and direct individuals to cessation programs.
- Monitor the effectiveness of educational materials and messages.

**Objective 2**

Encourage oral cancer screenings as the standard of care for oral health and non-oral-health professionals.

**Activities**

- Educate and train non-oral-health professionals (e.g., physicians, nurse practitioners, physician assistants) to screen individuals for oral cancer and refer them to appropriate health professionals for follow-up care, as needed.
- Support continuing education programs in oral cancer screening for oral health professionals.

**GOAL 4**

Ensure that communities have access to oral-disease-prevention and injury-prevention programs.

**Objective 1**

Increase the percentage of communities with fluoridated water to 100 percent.

**Activities**

- Identify communities that do not have fluoridated water.
- Develop a plan to encourage implementation of community water fluoridation.

**Objective 2**

Increase access to fluoride for those who rely on well water.

**Activities**

- Provide access to well water testing for those who rely on well water.



- Ensure access to appropriate fluoride supplements for those who rely on well water.

### Objective 3

Increase the number of topical fluoride programs for preschool- and school-age children.

#### Activity

- Develop and implement a plan to encourage the integration of topical fluoride programs into preschool and school curricula.

### Objective 4

Ensure that adult day care programs provide access to oral disease and injury prevention programs.

#### Activity

- Develop and implement best-practice-based strategies for oral health programs for individuals in these settings.

### Objective 5

Ensure access to appropriate oral health care services for individuals with special health care needs.

#### Activity

- Develop and implement best-practice-based strategies for oral health programs for individuals with special health care needs.

### Objective 6

Require that individuals participating in contact sports and other physical activities use appropriate oral and facial safety equipment (e.g., mouth guards, face masks).

#### Activities

- Pursue mandated use of oral and facial safety equipment, as appropriate, in all school- and community-sponsored sports and other physical activities.
- Develop and implement a program for health professionals and school personnel on anticipatory guidance regarding the use of oral and facial safety equipment for individuals participating in sports and other physical activities.

### Objective 7

Provide dental sealant programs in public schools for children at high risk for oral disease.

#### Activities

- Identify school systems that do not have dental sealant programs.
- Provide technical assistance to school systems to develop and implement dental sealant programs.
- Promulgate the use of science and best practice guidelines for school-based dental sealant programs.
- Explore the feasibility of utilizing passive consent, opt-out only, in school systems to improve access to dental sealants.

### Lack of Preventive Oral Health Care for Individuals with Special Health Care Needs

Proactive, preventive oral health care is unattainable for most people with severe mental illness because few oral health professionals are trained to treat individuals with mental or physical disabilities.

## Oral Health Literacy and Education

*Vision Statement:* By 2015, the distinction between oral health and general health will begin to blur. Soon afterwards, oral health care will no longer be seen as ancillary but instead as a specialty within general health, much like cardiology, neurology, or internal medicine. Health professionals will refer individuals to dentists, as they would to any other specialists. Academic and continuing education courses will provide health care students and health professionals with consistent oral health messages to foster clear communication with the public. Individuals will begin to perceive oral health care as basic health care, understand its importance, and appreciate the benefits of good oral health. They will also begin to obtain, process, and understand basic information to access oral health care and to make appropriate decisions.



### **GOAL 1**

Enhance individuals' awareness of the relationship between oral health and general health and wellness to empower them to adopt good oral health behaviors supported by evidence-based practice.

#### **Objective 1**

Implement an oral health literacy and education campaign for the public with health professionals providing accurate, consistent, and tailored messages promoting oral health.

##### **Activities**

- Develop and promote strategies to increase oral health literacy using a multi-disciplinary approach (e.g., incorporating health professionals, educators, and social service providers).
- Develop and promote oral health messages that address differences in ages, cultures, and literacy levels tailored to various audiences (e.g., consumers, pregnant women, policymakers, health professionals, individuals with special health care needs).
- Train health professionals to clearly communicate oral health messages using health literacy principles.
- Integrate oral health messages into general health messages.
- Integrate oral health messages into existing campaigns (e.g., Dental Health Month; National Nutrition Month; Oral, Head, and Neck Cancer Awareness Month).
- Utilize traditional media and social networking channels to share oral health messages.

#### **Objective 2**

Increase education on promoting oral health and preventing oral disease and injury for staff working with children and adolescents in education and care settings, including WIC, Early Head Start, Head Start, Judy Centers, schools, and programs for those with special health care needs.

##### **Activities**

- Train parents, teachers, community health workers, and other caregivers in the prevention of oral disease and navigation of the oral health care delivery system.

- Provide education to parents to help them establish good oral health for their children, beginning during the prenatal period and continuing throughout the lifespan.
- Disseminate and share best practice oral health curricula, and/or develop oral health curricula focusing on children at high risk for oral disease in various education and care settings.
- Create educational programs on preventing oral injury for individuals involved in child and adolescent sports teams and physical activity programs.
- Partner with state and local athletic associations, school physical activity departments, and coaches to promote the use of mouth guards and face masks by children and adolescents who participate in sports and other physical activities.

### **Objective 3**

Increase knowledge about oral health among adults at high risk for oral disease.

#### **Activities**

- Educate women considering pregnancy and pregnant women about oral health care and injury prevention.
- Educate populations at high risk for oral disease (e.g., older adults, adults without insurance, individuals with disabilities) about oral health care.
- Identify oral health curricula, or, if necessary, develop curricula, and disseminate them to programs for adults.
- Train adult caregivers (e.g., community health workers; personal care attendants; and staff at nursing homes, assisted living facilities, group homes, shelters, and senior centers) about adults' oral health concerns.

### **Objective 4**

Promote the public's oral health through advocacy efforts.

#### **Activities**

- Support the sustainability of oral health coalitions.
- Develop key partnerships to advocate for oral health issues.
- Continue to build legislative efforts to improve the oral health of all Marylanders.
- Work with legislative champions in the federal and state governments to help support an oral health legislative agenda.
- Create a legislative caucus to promote oral health issues.
- Provide education and training in advocacy for oral health issues for the public, health advocates, and students in health professional training schools.
- Convene a statewide summit to discuss oral health issues and develop action strategies.

#### **Consequences of Lack of Oral Health Literacy**

A dentist said, "Not long after I assumed responsibility for the dental program, I met a 5-year-old boy who had lost all of his teeth to dental caries. He arrived at our program to have the remaining shards of teeth removed and was grateful to be out of pain when he ate. If only we had been able to reach the family and provide education on oral hygiene practices, he could still have his teeth."

## **Objective 5**

Enhance health professionals' and students' knowledge of the importance of oral health to overall health.

### **Activities**

- Integrate oral health content into curricula for students in the health professions to encourage them to value the importance of oral health to overall health, understand the relationship between oral disease and other diseases, and be aware of prevention strategies.
- Provide health professionals with continuing education (e.g., during grand rounds) on oral health topics.
- Develop interdisciplinary oral health curricula for medical, physician assistant, nursing, social work, and pharmacy students.



## **GOAL 2**

Enhance individuals' ability to navigate the oral health care system and to establish dental homes.

### **Objective 1**

Develop collaboration between oral health and other health and human services professionals (e.g., case managers, social workers, child care providers, child care administrators and staff, nursing home staff, older adult care providers, school nurses, school-based health center staff).

### **Activities**

- Increase awareness among health and human services professionals about the range and availability of oral health services.
- Collaborate with Medicaid and third-party insurance payers in developing messages about the oral health care system and how to navigate it.
- Evaluate and disseminate best practice models in care coordination and case management for navigating the oral health system.
- Develop training programs for families and health and human services professionals about navigating the oral health care delivery system.

## **GOAL 3**

Promote primary care health professionals' and specialists' awareness and knowledge of the importance of oral health interventions for medically compromised individuals.

### **Objective 1**

Increase primary care health professionals' and specialists' awareness and knowledge of how to achieve optimal oral health for medically compromised individuals.

### **Activities**

- Create a checklist for health professionals (e.g., physicians, nurse practitioners, physician assistants) that includes medical interactions with dental procedures and contraindications.
- Encourage collaboration between general health and oral health professionals to ensure that oral health needs are addressed before initiating treatment for cancer, osteoporosis, and other medical conditions.

## **GOAL 4**

Enhance oral health professionals' ability to work with diverse populations.

### **Objective 1**

Increase oral health professionals' knowledge and skills in working with diverse populations.

#### **Activities**

- Develop and provide cultural sensitivity and diversity training for undergraduate and graduate dental and dental hygiene students.
- Develop and provide continuing education courses in cultural sensitivity and diversity for oral health professionals.

## **GOAL 5**

Enhance the public's awareness of evidence-based preventive strategies for improving oral health.

### **Objective 1**

Increase the public's awareness of the benefits of topical fluoride in preventing and reducing dental caries.

#### **Activities**

- Create public service announcements (e.g., radio and TV spots, billboards) about the benefits of topical fluoride.
- Utilize best-practice education resources, including those developed by federal and state governments, on the benefits of topical fluoride.
- Develop educational materials on the benefits of topical fluoride.
- Collaborate with dental product companies to support, develop, and disseminate educational materials about topical fluoride for the public.
- Increase the use of dental hygienists to promote and apply topical fluoride.



## Objective 2

Enhance the public's awareness of the benefits of fluoridated water in preventing and reducing dental caries.

### Activities

- Create public service announcements (e.g., radio and TV spots, billboards) about the benefits of fluoridated water.
- Utilize best practice education resources, including those developed by federal and state governments, on the benefits of fluoridated water.
- Develop educational materials on the benefits of fluoridated water.

## Objective 3

Increase the public's awareness of the benefits of dental sealants in preventing and reducing dental caries.

### Activities

- Create public service announcements (e.g., radio and TV spots, billboards) about the benefits of dental sealants.
- Collaborate with dental product companies to support, develop, and disseminate consumer-education materials on dental sealants.
- Enhance the public's awareness of the Office of Oral Health, Department of Health and Mental Hygiene's 2010 sealant demonstration project on the importance of dental sealants for children at high risk for oral disease.
- Utilize existing websites (e.g., Mighty Tooth Sealant Project) to promote dental sealants.
- Build parent and child advocacy groups' understanding of the importance of dental sealants.
- Utilize dental hygienists to promote and apply dental sealants to the teeth of children at high risk for oral disease.
- Utilize best practice education resources, including those developed by federal and state governments, on the benefits of dental sealants.
- Develop educational materials on the benefits of dental sealants.



# References

1. U.S. Department of Health and Human Services. 2000. Oral Health in America: A Report of the Surgeon General. Rockville, MD: National Institute of Dental and Craniofacial Research. <http://silk.nih.gov/public/hck1ocv.@www.surgeon.fullrpt.pdf>.
2. Altema-Johnson D. 2010. The Burden of Oral Diseases in Maryland. Baltimore, MD: Maryland Department of Health and Mental Hygiene, Office of Oral Health. [http://fha.maryland.gov/pdf/oralhealth/Burden\\_of\\_Oral\\_Diseases\\_in\\_Maryland\\_May2010.pdf](http://fha.maryland.gov/pdf/oralhealth/Burden_of_Oral_Diseases_in_Maryland_May2010.pdf).
3. Manski RJ, Chen H, Chenette RR, Collier S. 2007. Survey of the Oral Health Status of Maryland School Children 2005–2006. Baltimore, MD: Maryland Department of Health and Mental Hygiene, Office of Oral Health. [http://fha.maryland.gov/pdf/oralhealth/Oral\\_Health\\_Survey\\_Report.pdf](http://fha.maryland.gov/pdf/oralhealth/Oral_Health_Survey_Report.pdf).
4. Centers for Disease Control and Prevention. 2006 Water Fluoridation Statistics [website]. <http://www.cdc.gov/fluoridation/statistics/2006stats.htm>.
5. Poppell CF, Groves C, Dwyer DM, Sage K, Hussein CA. Cancer Report 2010. 2010. Baltimore, MD: Maryland Department of Health and Mental Hygiene, Cigarette Restitution Fund Program. [http://fha.maryland.gov/cancer/surv\\_data-reports.cfm](http://fha.maryland.gov/cancer/surv_data-reports.cfm).
6. Thompson TA, Cheng D. 2009. Focus on Oral Health Among Women Giving Birth 2004–2007. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health, Department of Population and Reproductive Health; Baltimore, MD: Maryland Department of Health and Mental Hygiene. [http://fha.maryland.gov/pdf/mch/oral\\_health.pdf](http://fha.maryland.gov/pdf/mch/oral_health.pdf).
7. Centers for Disease Control and Prevention. Behavior Risk Factor Surveillance System Prevalence and Trends Data [website]. <http://apps.nccd.cdc.gov/BRFSS>.
8. Maryland Department of Health and Mental Hygiene, Dental Action Committee. 2007. Access to Dental Services for Medicaid Children in Maryland. Baltimore, MD: Maryland Department of Health and Mental Hygiene, Dental Action Committee. [http://www.fha.state.md.us/pdf/oralhealth/DAC\\_Final\\_Report.pdf](http://www.fha.state.md.us/pdf/oralhealth/DAC_Final_Report.pdf).
9. Roberts K, Thuku N, Redd J. 2009. Access to Oral Health Care in Maryland: A Discussion of Policy Issues [unpublished manuscript]. Baltimore, MD: Maryland Department of Health and Mental Hygiene, Office of Oral Health.
10. Health Resources and Services Administration. Find a Health Center [website]. [http://findahealthcenter.hrsa.gov/GoogleSearch\\_HCC.aspx](http://findahealthcenter.hrsa.gov/GoogleSearch_HCC.aspx).
11. University of Maryland Dental School, Dental School. About Us [website]. <http://www.dental.umaryland.edu>.
12. Maryland Board of Dental Examiners, personal communication, December 2010.
13. Health Resources and Services Administration. Find Shortage Areas: HPSA by State & County [website]. <http://hpsafind.hrsa.gov>.
14. Henry J. Kaiser Family Foundation. State Medicaid Fact Sheets [website]. <http://www.statehealthfacts.org/profileglance.jsp?rgn=22&rgn=1>.
15. Maryland Department of Health and Mental Hygiene. 2009. Maryland's 2009 Annual Oral Health Legislative Report. Baltimore, MD: Maryland Department of Health and Mental Hygiene. [http://dhmh.maryland.gov/reports/pdf/2009/oct09/FHA/13-2504\\_HB70\\_JCRp82\\_MA\\_FHA\\_Oral%20Health%20Final.pdf](http://dhmh.maryland.gov/reports/pdf/2009/oct09/FHA/13-2504_HB70_JCRp82_MA_FHA_Oral%20Health%20Final.pdf).
16. Health Resources and Services Administration, Maternal and Child Health Bureau. 2005. The Oral Health of Children: A Portrait of States and the Nation, 2005. Rockville, MD: Health Resources and Services Administration, Maternal and Child Health Bureau. <ftp://hrsa.gov/mchb/oralhealth/oralhealth.pdf>.

17. Center for Maternal and Child Health and The Parents' Place of Maryland. Survey for Children with Special Health Care Needs [preliminary results].
18. U.S. Department of Health and Human Services. 2000. Healthy People 2010: Understanding and Improving Health, 2<sup>nd</sup> ed. Washington, DC: U.S. Department of Health and Human Services. <http://www.healthypeople.gov/2010>.
19. Tinanoff N, Lowe E, Holt K, Goodman H. 2010. Maryland's Mouths Matter: Fluoride Varnish and Oral Health Screening Programs for Kids—Training for EPSDT Providers in Maryland. Washington, DC: National Maternal and Child Oral Health Resource Center; Baltimore, MD: Maryland Department of Health and Mental Hygiene, Office of Oral Health. <http://www/ohmdkids.org/flvarnish>.
20. Maryland Medicaid Program, personal communication, January 2011.
21. Poppell C, Groves C, Gugel D, Dwyer DM. 2008. Cancer Report 2008. Baltimore, MD: Maryland Department of Health and Mental Hygiene. [http://crf.maryland.gov/pdf/crf\\_can\\_rpt\\_2008.pdf](http://crf.maryland.gov/pdf/crf_can_rpt_2008.pdf).
22. American Academy of Periodontology, Research, Science, and Therapy Committee. 1999. Position paper: Tobacco use and the periodontal patient. *Journal of Periodontology* 70(11):1419–1427.
23. Samet JM. 1992. The health benefits of smoking cessation. *Medical Clinics of North America* 76(2):399–414.
24. Centers for Disease Control and Prevention. CPONDER—CDC's PRAMS On-line Data for Epidemiologic Research [website]. <http://www.cdc.gov/prams/CPONDER.htm>.
25. National Cancer Institute and Centers for Disease Control and Prevention. SEER Cancer Profiles [website]. <http://statecancerprofiles.cancer.gov/cgi-bin/quickprofiles/profile.pl?24&003>.
26. Oral Cancer Prevention Committee. Oral Health. In press. In Maryland Comprehensive Cancer Control Plan.
27. Poppell CF, Hopkins A, Zhan M, Steinberger EK, Groves C, Gugel, Dwyer DM. 2009. Maryland Cancer Survey, 2008. Baltimore, MD: University of Maryland, Department of Epidemiology and Preventive Medicine; Maryland Department of Health and Mental Hygiene, Center for Cancer Surveillance and Control. [fha.maryland.gov/pdf/cancer/2008\\_MCS\\_report.pdf](http://fha.maryland.gov/pdf/cancer/2008_MCS_report.pdf).
28. U.S. Department of Health and Human Services. 2003. Child Maltreatment 2001. Washington, DC: Government Printing Office.
29. Maryland Office of the Secretary of State. COMAR Online (website). Family Law Article §5-704 and §5-705. <http://www.dsd.state.md.us/comar>.
30. Love C, Gerbert B, Caspers N, Bronstone A, Perry D, Bird W. 2001. Dentists' attitudes and behaviors regarding domestic violence. The need for an effective response. *Journal of the American Dental Association* 132(1):85–93.
31. Mid Atlantic PANDA [website.] <http://www.midatlanticpanda.org>.
32. Nielsen-Bohlman L, Panzer, AM, Kindig DA (eds.), Board on Neuroscience and Behavioral Health, Committee on Health Literacy. 2004. Health Literacy: A Prescription to End Confusion. Washington, DC: National Academies Press.



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