oral health

During Pregnancy & Early Childhood: Policy Brief

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Oral health plays an important role in overall health and well-being, as well as a special role during pregnancy. Good oral health has the potential to improve the health and well-being of women during pregnancy and contributes to improving the oral health and well-being of their children. Preventive and restorative dental treatment during the perinatal period is safe and results in better health outcomes. Conversely, delaying necessary treatment could result in harm to the mother. However, oral health care is not routinely considered a part of comprehensive perinatal health care; and many women do not visit a dentist before, during or after pregnancy, even when there are obvious signs of oral disease.

The reasons women do not receive oral health care during pregnancy are many, but prime among these are misconceptions among patients and providers (both perinatal and dental) about the importance and safety of such care. In addition, many women face barriers to care because they lack insurance coverage for dental care or they are unable to identify providers willing to accept public insurance coverage, such as Medicaid.

This policy brief is a supplement to recommended practice guidelines for the delivery, timing and scope of oral health services for women during the perinatal period. These recommendations, which can be found in Oral Health During Pregnancy and Early Childhood: Evidence-Based Guidelines for Health Professionals[1] (Guidelines), were developed through collaboration between the California Dental Association Foundation (CDA Foundation) and the American College of Obstetricians and Gynecologists, District IX (ACOG District IX). Primarily, this brief provides recommendations about how these guidelines can be implemented most effectively among the many audiences and partners involved in the delivery of perinatal care. The Guidelines were developed in 2009 by an expert panel of medical and dental professionals who were engaged to review scientific literature on the relationship between health and oral health status, treatment of oral diseases, and pregnancy outcomes. The review consisted mainly of evidence published after the release of guidelines developed by the New York State Department of Health in 2006.[2] The Guidelines are designed for multiple audiences, including prenatal, oral health, and child health professionals, as well as staff of community-based programs. They suggest specific steps that each care group can take to promote and facilitate use of oral health services during the perinatal period.

The following consensus statement was developed by the expert panel convened to create the Guidelines:

Perinatal Oral Health Consensus Statement

Prevention, diagnosis and treatment of oral diseases, including needed dental radiographs and use of local anesthesia, are highly beneficial and can be undertaken during pregnancy with no additional fetal or maternal risk when compared to the risk of not providing care. Good oral health and control of oral disease protects a woman's health and quality of life and has the potential to reduce the transmission of pathogenic bacteria from mothers to their children.

Oral health care is essential and safe during the perinatal period for mothers and their children.

It is increasingly recognized that oral health plays an important role in overall health and well-being; yet many women do not visit a dentist before, during or after pregnancy, even when there are obvious signs of oral disease.[3] Current understanding of maternal and fetal physiology indicates that the benefits of providing dental care during pregnancy far outweigh potential risks.[4] Prevention, diagnosis and treatment of oral diseases, including needed dental radiographs and use of local anesthesia, are highly beneficial and can be undertaken during pregnancy with no additional fetal or maternal risk when compared to the risk of not providing care.[5] Further, assessment of oral health risks in infants and young children with appropriate follow-up and treatment, along with anticipatory guidance for parents and other caregivers, has the potential to prevent early childhood caries (ECC).[6] Many medical and prenatal providers are not aware that the bacteria that cause ECC can be transmitted from mother to child. Early colonization of these bacteria in the child's mouth puts the child at greater risk of ECC. Untreated dental caries in the mother and other caretakers is associated with increased likelihood of dental caries in her child.

Barriers to Receiving Perinatal Oral Health Care

Despite the multiple benefits of oral health care, many women do not receive dental care during pregnancy. During 2002-2007, 65% of all women delivering in California received no dental care during pregnancy, and more than half (52%) reported having a dental problem prenatally; 62% of those reporting a dental problem during pregnancy received no dental care. The percentage of women who received no dental care was highest among women who were younger, poorer or nonwhite. Seventy-nine percent of women enrolled in Medi-Cal (California's Medicaid program) did not receive any dental care during pregnancy.[7]

Barriers and limits to utilizing dental services and improving oral health for pregnant women and their children are multifaceted and complex, and relate both to the health care system and to the client herself. Studies have shown that both perinatal and oral health care providers have an inadequate understanding of the importance and safety of oral health care and that this misunderstanding negatively impacts the provision of dental care during pregnancy. Similarly, many dentists needlessly withhold or delay treatment to pregnant women because of a fear of injuring either the woman or the fetus—or because of an unfounded worry about litigation.

Further obstacles exist within the health care system itself, including lack of insurance, low public-program reimbursement levels, lack of provider training, maldistribution of resources, capacity challenges, and lack of cultural competency among dental providers. Populations that face the most barriers and have the greatest need include the uninsured and those covered by publicly funded programs. Barriers to adequate care also arise from the misconceptions and needs of pregnant women themselves. For example, many misperceive need, lack knowledge about the importance of oral health, face financial challenges (including lack of dental insurance or lack of knowledge that Medi-Cal covers some dental services for pregnant women), fear dental care, or have issues related to transportation, child care, and balancing work and health care needs.

Reducing system-level barriers to accessing oral health care is essential. Certain aspects of the oral health service delivery system act as barriers to providing adequate oral health education and care to women during the perinatal period. The following are descriptions of gaps in the system, as well as strategies to address them.

Lack of insurance or underinsurance prevents many women from accessing oral health care during the perinatal period.

Nearly 30% of women of child bearing age (29.4%) nationally have no insurance for dental care.[8] Without insurance, access to services is severely restricted. Uninsured women and those whose coverage lacks comprehensive dental benefits face high out-of-pocket costs for oral health services, especially if they have complex treatment needs.[9] Individuals with public coverage such as Medi-Cal may not be aware that dental services are a covered service[10] (although adult dental coverage was severely restricted in 2009 as a result of California's precarious financial condition) or are unable to locate a dentist willing to accept their form of insurance.

Many health professionals, advocates and patients lack knowledge about the importance and safety of dental care during the perinatal period.

Perinatal care providers (obstetricians, midwives, nurse practitioners, family physicians, pediatricians, etc.) are often the first health professionals to consult with pregnant women to discuss how to prepare for a healthy pregnancy. These health professionals can play a critical role in emphasizing the importance of oral health and connecting pregnant women to sources of dental care. Although some health profession schools, residency programs, and continuing education efforts do include oral health in their curricula, the practice is not widespread.[11] Similarly, dental school curricula do not address care delivery during pregnancy or very early childhood routinely or adequately. The result is that many providers are limited in their scope of practice to their professional discipline and can miss opportunities to help women obtain the comprehensive services they need, including dental care.

Women need clear information about oral hygiene and oral health care.

Expectant parents are especially receptive to health promotion messages; and, as such, pregnancy is an opportunity to integrate oral health promotion into healthy pregnancy planning efforts. However, pregnancy also presents challenges that can compete with women's efforts to engage in health-promoting behaviors. For example, the physical effects of pregnancy may hinder positive oral health behaviors. In addition, food cravings may lead to frequent consumption of sugary snacks and to a corresponding increased risk of caries.[12] Finally, individual characteristics, such as age, cultural differences, and early life experiences with oral health care can all exert a strong influence on beliefs about the importance of oral health, oral hygiene, and nutritional practices.[13]

There are many opportunities for maternal and child health leaders, health professional associations, policymakers, community-based organizations, advocates, and other stakeholders to respond to the need for improvements in the provision of oral health services to women during the perinatal period. Wide dissemination of the Guidelines among all who provide services to pregnant women—medical and oral health professionals, community-based organizations, and advocates—is one of the most important first steps toward broad adoption of the practices recommended. Additional specific strategies are detailed in the following section.

Promote the use of the Guidelines in addressing oral health during the perinatal period.

- Professional associations and other maternal and child health-related organizations (such as ACOG, CDA and the Association of California Maternal, Child and Adolescent Directors can formally endorse the Guidelines. Endorsements can be through policy statements that both support the Guidelines and commit to informing 1) their members about the importance of incorporating the practices into their work and 2) their clients about the importance of incorporating the practices into their lives. For example, the American Academy of Periodontology has informed its members by issuing a statement on periodontal management of the pregnant patient,[14] as has the American Academy of Pediatrics policy statement, Preventive Oral Health Intervention for Pediatricians.[15]

- These formal organizational policies and the Guidelines should be disseminated through platforms such as articles in newsletters and policy briefs to encourage implementation of the Guidelines in private practice as well as in community-based practice settings and organizations.

- The California Department of Public Health should utilize the Guidelines to establish and/or revise policy and practice in Maternal, Child and Adolescent Health programs, including population-specific programs such as California's Perinatal Services Program and Black Infant Health Program. Each of these has responsibilities for programs and policies that affect pregnant women and young children and are in a position to ensure that the Guidelines, particularly those related to referrals and education, are incorporated into the programs' practices and education materials.

- The California Department of Health Care Services should endorse the Guidelines and use them to establish and/or revise policy and practice in Medi-Cal, Denti-Cal and the Child Health and Disability Prevention program to encourage coverage of preconception dental care for women, expand dental benefits for pregnant women (currently limited to exams, some preventive services and periodontal treatment), add coverage for anticipatory guidance/risk assessment for children, and add sealants for children and adults at high risk for developing caries. Other state Medicaid and CHIP programs should follow suit.

Expand opportunities to educate health professionals on risk assessment, prevention, and treatment of dental problems during the perinatal period.

- As indicated, most health profession schools, residency programs, and continuing education programs do not include oral health in their curricula, nor do dental school curricula address care delivery during pregnancy or very early childhood routinely or adequately. Greater collaboration between disciplines in designing curricula to integrate medical and oral health needs is a necessary step toward creating the groundwork for changing practice patterns. For example, several collaborative programs initiated between dental and medical schools have shown positive influence on physician practice.[16,17,18] While curriculum change in academia occurs slowly, the availability of evidence-based research is a key factor in supporting faculty willingness to make modifications.

- Because they have not been trained to understand the relationship between oral health and overall health, many perinatal providers fail to refer their patients regularly for dental care. A coordinated effort between the oral health and obstetrical communities needs to occur to improve maternal and child oral health outcomes. This could happen through cross-discipline education at professional meetings and other training opportunities designed to share information among practicing dentists, perinatal care providers, and others involved with the care of women during the perinatal period.

- Resources that complement the Guidelines are available for clinical providers, policymakers, public health officials, and the public on the importance of perinatal and infant oral health through the Improving Perinatal and Infant Oral Health Project, a collaborative effort of the American Academy of Pediatric Dentistry (AAPD) and the Children's Dental Health Project. A detailed project description can be accessed at www.cdhp.org/programs/improving_perinatal_and_infant_oral_health_aapd/improving_perinatal_and_infant_oral_health_.

- Another source for professionals is Bright Futures in Practice: Oral Health Pocket Guide, developed by the National Maternal and Child Oral Health Resource Center. The Pocket Guide is designed to help health professionals implement specific oral health guidelines during pregnancy, infancy, early childhood, middle childhood, and adolescence. It addresses risk assessment for dental caries, periodontal disease, malocclusion, and injury. It is available at www.mchoralhealth.org/pocket.html.

Ensure women's access to comprehensive medical and dental services before, during and after pregnancy.

- As indicated, large numbers of women lack insurance coverage. National insurance reform that guarantees comprehensive coverage is a critical step toward ensuring that perinatal oral health needs are met. Short of wholesale reform, states can take advantage of opportunities to expand existing programs such as Medicaid and the Children's Health Insurance Program (Medi-Cal and Healthy Families in California) to cover more comprehensive dental care for pregnant women, preconception dental care for all women, and dental coverage of higher income groups as well as to ensure that all who are eligible for these programs are enrolled.
- In California, the Access for Infants and Mothers program (AIM) is a small but important state coverage program for pregnant women. Although otherwise comprehensive, it excludes dental care. The Managed Risk Medical Insurance Board should use its influence as the recipient of CHIP federal funds for AIM to encourage the program to include dental care. States with similar programs should advocate for the inclusion of dental care as well.
- States have the option to provide adult dental benefits as a part of the Medicaid program. In 2009, California restricted Medicaid (Medi-Cal) dental benefits to a select group of adults, including pregnant women. (The benefit is limited to exams, cleanings, fluoride application, and treatment of periodontal disease; it does not cover restorative care.) Advocacy is needed to reinstate the dental benefit to all Medi-Cal beneficiaries and make dental care a federally mandated benefit for all adults enrolled in the Medicaid program to ensure that women receive dental care prior to conception and postpartum. States should also take advantage of any opportunity to offer CHIP (Healthy Families in California) dental benefits to individuals who have medical coverage through other means but are uninsured for dental care (so-called "wraparound" coverage).

- While reimbursement rates are not the sole factor determining providers' willingness to accept patients, low payment is associated with low participation in public programs. Medicaid is particularly significant to dental care of pregnant women as this program covers approximately one-third of births in the United States (and nearly half in California). Medicaid reimbursement rates must be increased to more closely reflect market rates, and cumbersome regulations and paperwork should be streamlined.
- Develop innovative options for expanding the availability of dental care and utilize all members of dental and medical teams—such as midwives, nurse practitioners, and registered dental hygienists in alternative practice—to their full capacity.
- Provide women with information about how to improve oral hygiene and access oral health care resources, as well as education on the importance of preconception health and oral health care
- Policy and financial support is needed for provision of anticipatory and other guidance to parents in nonmedical and nondental settings that parents frequent, such as Women, Infants and Children program offices.
- Excellent materials in English and Spanish are available through the National Maternal and Child Oral Health Resource Center, available at www.mchoralhealth.org/publications.html. Another good source is www.everywomancalifornia.org, which includes information and handouts on oral health for women. (See the "Healthy Body" link.) Additional materials are needed that focus on the importance of good oral health and oral health care prior to conception, during pregnancy, and afterward for women and children, especially information that is made available through alternatives to written media, such as video.

Expand advocacy and education for perinatal oral health.

- With funding from the American Dental Association Foundation, the American Academy of Pediatrics (AAP) has established a program in which a representative from each of the 66 AAP chapters will be trained to serve as a chapter oral health advocate (COHA). The COHA will function as the chapter's oral health expert—offering trainings on incorporating oral health assessments into well-child visits; establishing collaborative relationships with general dentists, pediatric dentists, and state and local dental organizations to improve children's oral health in their communities; and providing oral health technical assistance to chapter members. This model should be expanded to include perinatal providers as well.

- All public perinatal programs that incorporate oral health education, such as the California Perinatal Services Program, should be supported with sufficient resources to ensure that all eligible women receive comprehensive care.

Conclusion

Early, ongoing dental services are an essential part of comprehensive perinatal care, yet far too few pregnant women (and women of childbearing age who are potentially pregnant) receive dental services. Oral Health During Pregnancy and Early Childhood: Evidence-Based Guidelines for Health Professionals, based on clinical and epidemiological evidence of efficacy and safety, offer recommendations for services and education directed at both perinatal and oral health services providers. Widespread dissemination and adoption of these Guidelines will promote the health and well-being of women and children. Yet, multiple system-level barriers make it difficult for many women to access oral health services. This brief offers specific strategies for mitigating some of these barriers. While examples of these strategies focus on opportunities in California, many are applicable to other states and/or can be adopted nationally. Ultimately, national practice guidelines and system-level reforms to ensure access to comprehensive perinatal and oral health care are needed to best protect and promote the health and well-being of women and children.

1 Oral Health During Pregnancy and Early Childhood: Evidence-Based Guidelines for Health Professionals; CDA Foundation, February 2010.

2 An Advisory Committee of professionals representing statewide organizations in public and private clinical practice, research, health education and policy was formed to guide the development of the Guidelines. For more information on the process by which the Guidelines were developed and which organizations and individuals were involved, see Oral Health During Pregnancy and Early Childhood: Evidence-Based Guidelines for Health Professionals; CDA Foundation, February 2010.

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Oral Health During Pregnancy and Early Childhood: Evidence-Based Guidelines for Health Professionals can be downloaded from www.cdafoundation.org/guidelines.

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