Oral Health and Older Adults: A History of Public Neglect

By Michèle J. Saunders

A comprehensive look at policy movement and change around oral healthcare for older adults.

Generations journal has been published for nearly forty years, yet this Fall 2016 issue is the first to focus on oral health. In the early 1970s, more than 55 percent of older adults were completely edentulous (without teeth). Since then, one of the goals of the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) has been to reduce the edentulous rate to only 10 percent. As the number of elders with teeth has increased, oral health professionals have had to learn more about geriatrics. Unfortunately, other health and health service professions have not learned more about oral health.

America's healthcare culture is largely unaware that many low-income elders have died from untreated oral disease.

There is a good reason for this: our healthcare culture sees the mouth as "only a tooth" instead of as an integral part of the body. Moreover, if oral health had been included in overall health insurance all these years, it would have helped broaden the view that oral healthcare is a necessary component of primary care. This healthcare culture is largely unaware that many low-income elders, who are often, though not always, institutionalized, have died from untreated oral disease.

How did we get to this point?

A Long Journey: Integrating Oral Care with Overall Healthcare

In 1988, then-Surgeon General C. Everett Koop held the Surgeon General's Workshop on Health Promotion and Aging for 180 invited attendees, yet only seventeen participants focused on oral health. The Surgeon General had already held eight workshops, and this was the first to include oral health as a topic. The group made several recommendations in the areas of education, service, research, and policy, and those relevant to this issue of *Generations* are included in the sidebar on page 8 (HHS and AOA, 1988).

These recommendations were made twenty-eight years ago, and while there has been some improvement in following a few of them, and good progress made with others, there has been

→ABSTRACT Oral health and general health are interwoven. Disparities in oral healthcare exist for underserved and vulnerable older adults. Since 1988, many studies have been conducted and reports written with recommendations by the Surgeon General, IOM, CDC, and HHS. The lack of public financing for preventive or routine oral healthcare for older adults enrolled either in Medicare or Medicaid has prevented action on many recommendations in these reports. Now is the time to support publicly funded oral healthcare for this vulnerable, underserved population. **| key words**: *oral health and aging; dental care and aging; underserved older adults; dental care and Medicare; dental care and Medicaid; Surgeon General and oral health; IOM and oral health; HRSA-HHS and oral health*

Policy and Strategic Principles

1. Oral health is an integral part of total health, and oral health care is an integral part of comprehensive health care, including primary care.
2. A qualified dental work force is a valuable national resource, and support for the education of this work force must continue to come from both public and private sources.
3. In recruiting students and faculty, designing and implementing the curriculum, conducting research, and providing clinical services, dental schools have a responsibility to serve all Americans, not just those who are economically advantaged and relatively healthy.
4. Efforts to reduce the wide disparities in oral health status and access to care should be a high priority for policymakers, practitioners, and educators.

Source: Field, 1995

little to no improvement in seven of the recommendations listed in this article.

Why has progress been so minimal?

Two years after the workshop report was released, leaders in dental education asked the Institute of Medicine (IOM) to conduct an independent assessment of dental education. Many dental schools had closed, and they were worried about the future of dental education. The IOM conducted an extensive five-year study and in 1995 released *Dental Education at the Crossroads: Challenges and Change*. The sidebar on this page lists selected key policy and strategic principles from this report (Field, 1995).

These principles are covered in many of the articles in this issue of *Generations*. See Yellowitz's article on page 60; Ettinger and Cowen's article, page 66; and Roberts and colleagues' article, page 79; these describe distinctive programs to build and train the professional workforce. Also see articles that discuss innovative models to deliver oral care for older adults: Becerra and Nguyen, page 100; Chávez and Lederman, page 104; and Wiseman, page 108.

The IOM study committee envisioned an ideal future for dentistry, stating five key elements:

> First, *dentistry will and should become more closely integrated with medicine and the health care system on all levels: education, research, and patient care* . . . Second, *to prepare their students and their schools for change, dental educators will need to teach and display desirable models of clinical practice.* Third, *securing the resources essential for educational improvement and, indeed, survival will require that dental schools demonstrate their contributions to their parent universities, academic health centers, and communities . . . dentistry cannot afford isolation* . . . Fourth, *dental leaders should cooperate to reform accreditation and licensing practices so that they support rather than obstruct the profession's evolution* . . . Fifth, *continued testing of alternative models of education, practice, and performance assessment for dentists and allied dental professionals is necessary to prepare the dental community—educators, practitioners, regulators, and policymakers—for an uncertain future . . . If a shortage in dental services should develop, responses should emphasize more productive use of allied dental personnel* . . . (Field, 1995).

Some schools attempted to follow this direction regarding more productive use of allied health personnel, and a few developed unique programs for expanded functions for dental hygienists and dental assistants that improved their use in dental practices. But organized dentistry fought anything it considered too advanced, such as independent practice for dental hygienists in all rural areas (though

Selected Oral Health Recommendations from the Surgeon General's 1988 Workshop

1. All health care providers should be educated in the relationship between oral and general health, including the contributions of each health care provider in maintaining oral health and function.
2. Educational programs should be available to develop competent educators and researchers in all areas pertinent to the achievement and maintenance of oral health in the older adult.
3. Appropriate curriculum guidelines and accreditation standards specific to meeting the oral health needs of older adults should be developed and reflected in licensure, certification, and national board examinations for all health disciplines.
4. Accurate and appropriately designed educational materials and other resources specific to the oral health needs of older adults should be developed or adapted and disseminated through all relevant agencies, services, and organizations.
5. Long-term care facilities should have an established oral health care program that includes timely and appropriate diagnostic, primary preventive, and restorative services.
6. Oral health services for older adults should be an integral part of public and private health benefits programs, including but not limited to Medicare Part B, Medicaid, employee retirement benefits, and other health insurance programs.
7. Special efforts in oral health promotion and service delivery should be directed to older adults who are currently underserved, such as Native Americans, the homebound, Hispanics, and blacks.
8. Federal guidelines for long-term care facilities should include a dental examination within 30 days after admission and annually thereafter; a program in oral primary prevention and health education for residents and staff; access to dental treatment when needed; and oral health status information in residents' medical charts. Reimbursement mechanisms should be developed to support these activities.
9. Access barriers to prevention and basic oral health services for older adults, such as financing, transportation, and physical barriers should be removed.

Source: HHS and AOA, 1988

Colorado and Oregon recognize such practices), just as it fought being included in Medicare. It also fought the concept of a master's level dental hygienist functioning as a "periodontal co-therapist" with the dentist.

To advance the nation's oral health, the IOM study committee restated some of the objectives that were originally in the 1988 Surgeon General's workshop concerning reducing disparities in oral health status and services among disadvantaged economic, racial, older adult, and other groups; encouraging oral disease prevention at the individual and community levels; and the education of non-dental healthcare practitioners (especially primary care providers), geriatricians, educators, and public health officials (Field, 1995).

There has been significant progress in individual and community oral disease prevention and oral health promotion, such as through increased patient oral hygiene instruction and tobacco cessation programs, as well as more communities with water supply fluoridation. Dentistry has also improved its knowledge of the best ways to prevent and treat oral health problems. However, reduction of disparities has been minimal and includes a focus on children's oral healthcare in the Medicaid Children's Health Insurance Program (CHIP). There is still a long way to go before disparities are adequately reduced, especially among vulnerable and underserved older adults. Nor has there been much progress in educating non-dental practi-

tioners about the importance of oral health and their role in assuring it improves.

Notably, the IOM study committee also insisted that:

> *Public support is critical if disparities in health status and access to oral health services are to be reduced. This committee therefore recommends that all parts of the dental community work together to secure more adequate public and private funding for personal dental services, public health and prevention programs, and community outreach activities, including those undertaken by dental school students and faculty* (Field, 1995).

This public support has only recently, and minimally, begun to manifest. While schools increased student rotations in various community settings, and dental hygiene students conducted more patient and community education projects, and some faculty at a few dental schools were awarded foundation grants for personal dental services, there was minimal change in non-dental practitioner education about oral health. There have been no oral health public service announcements on television.

Furthermore, the IOM committee recommended that future oral healthcare professionals should be prepared for more medically based oral healthcare and more medically complex patients. They specified that medical and dental students should have integrated basic science education; dental students should have some experience in related areas of medicine, as well as in ambulatory care clinics, hospitals, nursing homes, and other settings. While a handful of dental schools had already enacted some of this training since the 1970s, and others have added a few components, very few have combined classes for dental students with medical students. (See Shuman and Owen's article on page 70 for ethical issues in treating more complex patients.)

The IOM committee also recommended that the American Association of Dental Examiners, American Association of Dental Schools (now the American Dental Education Association), professional associations, state and regional boards, and specialty organizations "work closely and intensively to eliminate statutes and regulations that restrict dentists from working with allied dental personnel in ways that are productive and consistent with their education and training" (Field, 1995).

There has been very little movement in this area. To date, only Colorado and Oregon have independent practice for dental hygienists. Most state Boards of Dental Examiners will not allow dental hygienists to administer infiltration anesthesia in which injections are given into the space between the gums and the teeth to eliminate pain and discomfort during deep scaling and root planing by the dental hygienist. Dental students in more liberal states have dental hygiene faculty instructors who teach them infiltration anesthesia. Only recently have dental hygienists been able to practice in community settings under general supervision by a dentist (without the dentist having to be on site).

The IOM study committee felt strongly that in order for dental schools to survive and oral health status and future shortage of dental services to improve, educators and policy makers should continue to increase dental workforce productivity to improve the effectiveness, efficiency, and availability of dental care generally, "including appropriately credentialed and trained allied dental personnel" (Field, 1995). Dentistry has made some improvements through the years in this area. Unfortunately, it is far from having this practice nationwide. For now, every state has its own practice law, and there is no national standard for expanded functions for dental assistants and dental hygienists. One of many issues with this, for example, is that in Alabama, dental assistants are not permitted to put sealants on teeth, but in California they are permitted to do so, but only under general supervision (ADA, 2011). So many expanded functions for both dental hygienists and dental assistants vary from state to state, making it extremely dif-

ficult to uniformly change and improve the oral healthcare system.

The Surgeon General's report on oral health

Clearly not thrilled that change in the oral healthcare system was progressing at a snail's pace, in 2000, the Surgeon General released *Oral Health in America: A Report of the Surgeon General*. Again, a national oral health report made a clear argument for treating the mouth as part of the body, and oral health as a requirement for overall health, well-being, and quality of life. The report also highlighted the ongoing, unresolved disparities in oral healthcare, and reminded us that we need a National Oral Health Plan to "improve quality of life and eliminate health disparities by facilitating collaborations among individuals, health care providers, communities, and policymakers at all levels of society and by taking advantage of existing initiatives.

"Everyone has a role in improving and promoting oral health. Together we can work to broaden public understanding of the importance of oral health and its relevance to general health and well-being, and to ensure that existing and future preventive, diagnostic, and treatment measures for oral diseases and disorders are made available to all Americans" (HHS, 2000).

The report proposes five overarching components of a national plan, including changing perceptions about oral health and disease so oral health becomes an accepted part of general health by changing perceptions of the public, policy makers at local, state, and federal levels, and non-dental health professionals through multi-disciplinary education and team care; accelerating the building of the science and evidence base and applying science effectively to improve oral health; building an effective health infrastructure that meets the oral health needs of all Americans and integrates oral health effectively into overall health; removing known barriers between people and oral health services, especially issues of access, utilization, financing, and reimbursement of oral healthcare; and using public–private partnerships to improve the oral health of those who still suffer disproportionately from oral diseases (HHS, 2000). (See Wiseman's article in this issue, page 108, for one such successful public–private partnership.)

A call to action: a national plan and subsequent reports

The Surgeon General's 2000 report reinforced many of the calls to action of the 1988 workshop report. In 2003, the Surgeon General issued a follow-up National Call to Action to Promote Oral Health. This call to action rehashed the findings of the 2000 report and went into more detail on the five components of a National Oral Health Plan to effect an improvement in America's oral health. The Surgeon General wanted to reinforce the importance of the change that is needed to make this happen, because it was becoming common knowledge that oral disease is associated with cardiovascular disease, diabetes, and more, and that oral health services are medically necessary, ultimately saving healthcare dollars by preventing negative sequelae. The Call to Action's vision was to "advance the general health and well-being of all Americans by creating critical partnerships at all levels of society to engage in programs to promote oral health and prevent disease." This mission would accomplish the Healthy People 2010 goals of promoting oral health, improving quality of life, and eliminating oral health disparities (HHS, 2003).

During the next five years, critical partnerships began to form, but change was slow, especially with regard to access to quality oral healthcare for older adults. The IOM issued another report, *Retooling for an Aging America: Building the Health Care Workforce*, to address the dramatic change in the age distribution of the U.S. population, a shift causing stresses on the healthcare system. This IOM committee studied workforce issues such as education, training, modes of practice, and financing of public and private programs (IOM, 2008). This

report included the oral health workforce, along with that of other professions, and was more widely distributed across professions than any preceding report. By this time, it had become obvious that if oral health champions did not come from all levels of society, government, education, industry, non-dental practitioners, and patients, it would never reach fruition.

When Medicare was being developed, organized dentistry fought the inclusion of an oral healthcare benefit.

In 2010, the Health Resources and Services Administration (HRSA) requested the IOM conduct a study that would guide HRSA in the development of an Oral Health Initiative to advance oral health in America. At the same time, the IOM was conducting a second, totally independent study on oral health access to services for vulnerable and underserved populations. The belief at the time was that these two reports would build upon and reinforce each other, while emphasizing the significance of oral health to general health and well-being. It is important to recognize how influential and important are the reports and recommendations that are issued by the IOM. The medical and nursing professions have always paid attention to them, and have always been included on the study committees. Although no one leapt to make vast changes immediately, these two reports served their intended function: those in academia and the government were paying attention. They knew that HRSA has discretionary funds each year for training programs that meet the requirements they establish in response to internal review, and direction from the IOM, Congress, and other federal agencies.

The IOM released this first study of 2011, *Advancing Oral Health in America: A Report of the IOM Committee on an Oral Health Initiative*. The report highlighted the following seven recommendations:

First, *secretary of HHS should give the leader(s) of the New Oral Health Initiative (NOHI) the authority and resources needed to successfully integrate oral health into the planning, programming, policies, and research that occur across all HHS programs and agencies.* Second, *all relevant HHS agencies should promote and monitor the use of evidence-based preventive services in oral health (both clinical and community-based) and counseling across the lifespan.* Third, *all relevant HHS agencies should undertake oral health literacy and education efforts aimed at individuals, communities, and health care professionals.* Fourth, *HHS should invest in workforce innovations to improve oral health.* Fifth, *CMS should explore new delivery and payment models for Medicare, Medicaid, and CHIP to improve access, quality, and coverage of oral health care across the lifespan.* Sixth, *HHS should place a high priority on efforts to improve open, actionable, and timely information to advance science and improve oral health through research. And,* seventh, *to evaluate the NOHI, the leader(s) of the NOHI should convene an annual public meeting of the agency heads to report on the progress of the NOHI* (IOM, 2011).

Shortly after this report was released, the IOM committee released the second report that had been in study at the same time as the first, *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*. The IOM committee had conducted this study from 2009 to 2011, with two guiding evidence-based principles: Oral health is an integral part of overall health, therefore, oral healthcare is an essential component of comprehensive healthcare; and, oral health promotion and disease prevention are essential to any strategy aimed at improving access to care (IOM and the National Research Council, 2011).

Most importantly, after review of the evidence presented, the committee concluded that:

> *Improving access to oral health care is a critical and necessary first step to improving oral health outcomes and reducing disparities; the continued separation of oral health care from overall health care contributes to limited access to oral health care for many Americans; sources of financing for oral health care for vulnerable and underserved populations are limited and tenuous; and, improving access to oral health care will necessarily require multiple solutions that use an array of providers in a variety of settings* (IOM and the National Research Council, 2011).

The report had many recommendations. The ones most relevant to this issue of *Generations* include that the HRSA should convene key stakeholders from the public and private sectors to develop a core set of oral health competencies for non-dental healthcare professionals; then hopefully, accrediting bodies for undergraduate and graduate-level non-dental health professional education programs should integrate these core competencies into requirements for accreditation; and all certification and maintenance of certification for healthcare professionals should include demonstration of competence in oral healthcare; state legislatures should amend existing state laws, including practice acts, to maximize access to oral healthcare.

At minimum, state dental practice acts should allow allied dental professionals to practice to the full extent of their education and training; allow allied dental professionals to work in a variety of settings under evidence-supported supervision levels; and allow technology-supported remote collaboration and supervision; CMS should fund and evaluate state-based demonstration projects that cover essential oral health benefits for Medicaid beneficiaries; to increase provider participation in publicly funded programs, states should set Medicaid and CHIP reimbursement rates so beneficiaries have equitable access to essential oral health services, as required by law; provide case-management services; and streamline administrative processes; Congress, HHS, federal agencies, and private foundations should fund oral health research and evaluation related to underserved and vulnerable populations, including new methods and technologies (e.g., non-traditional settings, non-dental professionals, new types of dental professionals, and telehealth); measures of access, quality, and outcomes; and payment and regulatory systems; the CDC and the Maternal and Child Health Bureau should collaborate with states to ensure each state has the infrastructure and support necessary to perform core dental public health functions (e.g., assessment, policy development, and assurance); and expand the capacity of FQHCs to deliver essential oral health services (IOM and the National Research Council, 2011).

These recommendations from the two 2011 IOM reports are the backbone of the HHS's new Oral Health Initiative (now OHI) which is based on *Healthy People 2020*. There are thirty-one *Healthy People 2020* objectives listed as part of the OHI; only four mention adults older than age 65; and twelve more are across all ages (HRSA, 2011). It is well known that for the first time, America has a larger number of adults older than age 65 than it has children. Perhaps when funds are available for oral health services, HRSA will devote more attention in its OHI to older adults. Meanwhile, while we await changes in oral healthcare financing for older adults, all of the reports, beginning with the 1988 workshop report, fully coalesce into these two 2011 reports. Every segment of the healthcare system, medical and dental, was following the progress of change.

In 2014, HRSA's OHI released its report, *Integration of Oral Health and Primary Care Practice*, in response to the two 2011 IOM reports that stated HRSA should develop oral health competencies for non-dental health professionals. After two years of study, this report includes those competencies (HRSA, 2014).

In summer 2016, HHS released (somewhat retroactively) its *Oral Health Strategic Frame-*

work 2014–2017, developed by the U.S. Public Health Service (PHS) Oral Health Coordinating Committee in response to the IOM reports. This document serves as the roadmap for the OHI and all HHS activities to "prevent oral disease; increase access to services; develop and disseminate oral health information; advance public policy and research and translate policy and research into practice; strengthen the oral health workforce; and eliminate oral health disparities" (HHS, 2016). This is a tall order, but achievable with adequate resources.

Unfortunately, in writing the directions in 2014 for the HRSA Geriatric Workforce Enhancement Program (GWEP) federal funding opportunity, HRSA mistakenly caved under pressure from physician geriatricians who were afraid they would not be able to easily recruit dentist geriatrician fellows along with physician geriatrician fellows for a geriatric medical/dental/mental health fellowship. Thus, fellowships became optional in the GWEPs, and so did dental fellows. Hopefully, this oversight will be corrected in the next round of proposals for new GWEP funding in 2018.

A Post-Research Reflection: Parsing the Progress

Financing of oral healthcare for older people is an inadequately addressed issue. Organized dentistry fought to keep dental care out of Medicare, and won. For this reason, the public funding issue of oral healthcare has operated under the policy radar, except for dental care for poor children and tooth extractions required for certain high-risk medical conditions in adults (such as organ transplants and heart valve replacements).

OBRA '87 was the most far-reaching revision of nursing facility care in thirty-five years. In recognizing that oral health is an integral part of general health, this legislation also made nursing facilities directly responsible for their residents' dental care. Yet it has been minimally enforced because the law provided no federal dollars. It is time to include oral health services for older adults in Medicare and Medicaid benefits (for a discussion of financing issues, see the Chávez, Calvo, and Jones' article on page 94; Calvo, Chávez, and Jones' article on page 85; and Nagro's article on page 90).

There is no question that our health culture has minimized the importance of oral health, relegating it to a quality-of-life issue, not really seeing the mouth as an integral part of the body (see Erickson's article on page 25). Until we see beyond this narrow view, the healthcare system will not change as it should. Policy makers, healthcare providers, practitioners and third-party payors, and older adults and their families need improved oral health literacy to effect this change.

The Institute of Medicine (now the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine) issued the reports described above and in mid-September released *Families Caring for an Aging America* (IOM, Committee on Family Caregiving for Older Adults, 2016). The Oral Health Coordinating Committee of HHS has developed the *HHS Oral Health Strategic Framework 2014–2017* (HHS, 2016). Together, these reports and framework provide clear direction regarding the steps that should be taken.

The earlier reports have led to the development of the Eldercare Workforce Alliance in 2008 and the Santa Fe Group in 1995. These reports also have led to proposed legislation as described by Jessica Nagro in this issue of *Generations*. Even though the legislation has not yet passed, I foresee that legislation to include expanded oral healthcare services in Medicare will eventually pass if Congress can perceive the savings that will ultimately result from preventive and primary care dentistry.

The ideal objective of healthcare practitioners should be to render their profession obsolete. Dentistry has come closest to this of any health profession because of its prevention activities (see the Taverna, Nguyen, and Hicks article on page 43; and Messina's articles on

pages 19, 39, and 41). Yet, there is a long way to go, especially with an ever-increasing older adult population that becomes more frail with age. It will take the actions of dental education; the oral health industry; increased oral health literacy and subsequent collaboration in action among non-dental professionals; older adult patients and their families; local/state/national policymakers and program directors/managers; dentistry professionals; professional organizations and groups; dental school accrediting bodies; licensing bodies; interdisciplinary healthcare teams, (including dental professionals); and more to adequately improve oral health in older adults (see Yellowitz's article on page 60).

And if this work isn't done? Most likely the result will be more oral health problems in the older adult population. As the cohort grows, even if the percentage of those with poor oral health does not increase, the numbers will. Without preventive oral healthcare and routine dental care, the cost of the negative sequelae of untreated oral problems in older adults will mean increased expenditures to both the dental and medical healthcare systems because the mouth is an integral part of the body.

If oral disease is left untreated it will result in more systemic health problems and chronic comorbid diseases in older adults, which require more expenditures to manage, if not cure. More models of improving oral healthcare must be developed (for innovative models, see Ettinger and Cowen's article, page 66; Roberts et al., page 79; Wiseman, page 108; and Becerra and Nguyen, page 100).

Going Forward: Training, Advocacy, and Action

The United States rose to having the best oral healthcare in the world because once dentistry fully separated from medicine in the early 1920s and the population was largely edentulous by middle age, the profession was free to focus on developing dental techniques, dental materials, and oral healthcare products (see Messina's articles on pages 19, 39, and 41).

As adults in middle age began living longer and experiencing more chronic disease, dentistry and oral healthcare needed to become closer to medicine once again. This is because the use of antibiotics, anxiolytics (anti-anxiety medications), and analgesics (pain medications), along with advanced periodontal (gum and tooth-supporting bone) care and surgery, oral surgery, and dental implants, especially in the older adult, renders those patients at higher risk for negative sequelae of treatment. Therefore, dental health professionals at all levels of training must learn more medicine if they are to cause no harm.

There now are more courses for oral healthcare students and practitioners about the mouth-body connection and nutrition (see Erickson's and Chernoff's articles, page 25 and page 32) than ever before, including their application to older adult residents of nursing facilities (see Dirks' article, page 52).

Now is the time to act. Attention to oral health is reaching critical mass in all of the individuals, groups, organizations, and agencies mentioned above to finally move forward the agenda to improve the oral healthcare and, consequently, the oral health of older adults.

If we are ever going to improve the oral health of our country's older population by effecting policy change, it will require the combined advocacy of the health professions and groups that serve older people—and elders themselves.

Michèle J. Saunders, D.M.D., M.S., M.P.H., is an adjunct professor in the Department of Psychiatry at the University of Texas Health Science Center at San Antonio, where she also directs the South Texas Geriatric Education Center.

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