

Resolution No. N/A N/AReport: CAPIR Supplemental Report 3 Date Submitted: September 2012Submitted By: Council on Access, Prevention and Interprofessional RelationsReference Committee: Dental Benefits, Practice and HealthTotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0ADA Strategic Plan Goal: Members (Required)

**COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS SUPPLEMENTAL  
REPORT 3 TO THE HOUSE OF DELEGATES: FORMULATING A STRATEGIC APPROACH FOR  
ADDRESSING THE COMPLEX EMERGING ISSUES RELATED TO ORAL HEALTH AND NUTRITION IN  
THE UNITED STATES**

**Background:** At its January 2011 meeting, the Council on Access, Prevention and Interprofessional Relations (CAPIR), held an extended discussion on soda and sweetened beverages noting that these items may contribute to caries risk across the life-span. Additionally, the Council was informed that the Council on Communications had discussed soda consumption by young children at its meeting earlier in January. At the January 2011 meeting, CAPIR adopted an action requesting the ADA Board of Trustees form an interagency workgroup to discuss soda consumption and caries risk in young children and develop potential policy. In April 2011, the Board of Trustees asked CAPIR to review the issue and seek input from other agencies, as appropriate, on the development of policies for consideration by the House of Delegates.

At its June 2011 meeting, CAPIR adopted the following resolution:

**Resolved**, that CAPIR approves the formation of an oral health and nutrition ad hoc advisory committee to consist of representatives from, but not limited to, the Council on Communications, Council on Dental Practice, Council on Scientific Affairs, Council on Government Affairs and the Council on Access, Prevention and Interprofessional Relations, and other experts to formulate a strategic approach for addressing the complex emerging issues related to oral health and nutrition in the United States and to submit a report to the 2012 HOD.

The chairs of the Councils noted above were contacted and asked to appoint members to the ad-hoc committee. An ad-hoc committee was formed consisting of the following member representatives:

Dr. Rocky Napier, Council on Access, Prevention and Interprofessional Relations, chair  
Dr. Jonathan Shenkin, Council on Communications  
Dr. Jon Johnston, Council on Dental Practice  
Dr. Brian Novy, Council on Scientific Affairs  
Dr. Mary Jennings, Council on Government Affairs

In addition, Teresa Marshall, Ph.D., R.D., CAPIR consultant on nutrition issues, acted as expert consultant for the Oral Health and Nutrition Ad Hoc Advisory Committee. Council directors were contacted and an ADA staff member from each participating Council was assigned to the Committee to act as a liaison. This report reflects the majority opinion of the Advisory Committee.

In preparation for the Committee's discussions, members received the following background documents:

- 1 • the history and charge to the workgroup
- 2 • current ADA policies related to nutrition
- 3 • CAPIR reports on nutrition (June 2010-January 2012)
- 4 • links to nutrition-related content on ADA.org and nutrition-related products available through the *ADA*
- 5 *Catalog*
- 6 • guidance from the ADA Board of Trustees urging focus on fulfilling the ADA's Strategic Plan Goals 1
- 7 and 4

8 On February 22, 2012, members of the Committee convened by phone for the first of three conference calls.  
9 Subsequent calls were held on March 3, 2012, and March 21, 2012.

10 Four main points penetrated all of the Committee's discussions.

- 11 1. Oral health is dependent on proper nutrition (eating a well-balanced diet).
- 12 2. Oral health is dependent on good eating habits (limiting snacking and eating in between meals
- 13 [frequency of intake]).
- 14 3. It is not practical to classify some foods and beverages as being more or less harmful to oral health
- 15 than others.
- 16 4. The best way to get people to adopt healthier diets and establish better eating habits is through a
- 17 strong program of nutritional education that begins prenatally and continues throughout the life span.

18 Throughout the discussions, it became clear that the members' comments focused on four themes that could  
19 be used as a foundation in developing strategies to address issues related to oral health and nutrition.

- 20 • Best Available Science and Best Practices
- 21 • Role of Collaboration
- 22 • Communication/Education
- 23 • Development of Policy That Promotes Good Nutrition

24 **Best Available Science and Best Practices:** Additional evidence-based research is needed to ensure that  
25 the science base for nutritional education and recommendations are of the highest quality. However, while  
26 there will always be a desire for high-quality research, the fact is that it is extremely difficult to conduct  
27 randomized controlled nutritional studies on population groups. From an ethical perspective one cannot  
28 assign subjects to a cariogenic test group, thus nutritional studies rely heavily on the behavior of subjects. An  
29 individual's diet typically encompasses many food stuffs and intake patterns, each of which might have  
30 contradictory effects on caries and other health risks.

31 The Committee agreed that efforts are needed to determine how lower level evidence-based research, the  
32 best science that is currently available, can inform policy.

33 In this situation, identifying successful strategies, or best practices, that encourage individuals to adopt eating  
34 habits that maintain optimal oral health is key. In some cases, these best practices might best be determined  
35 at the state level by looking at state administered nutrition programs and populations. Consideration could be  
36 given to conducting pilot programs at this level through WIC or food stamp programs to see what actually  
37 works related to specific foods or eating patterns. The outcomes of these studies could inform further  
38 research and legislative strategies and policies.

39 **Role of Collaboration:** Dental providers need to be informed about their role in providing nutritional  
40 guidance to their patients and the role they can play in providing messaging about general health concerns  
41 such as obesity. Collaboration with primary health care providers and external agencies can also be an  
42 effective method to educate the public about the importance of good nutrition and the role good nutrition and  
43 good eating habits play in oral health. However, the dental community must first work to ensure that non-

dental providers understand the value of good oral health and the role dental professionals can play in improving not only the public's oral but general health through nutritional education.

Educating non-dental primary care providers about the importance of good oral health and developing a working relationship with these providers on a one-to-one and organizational basis is imperative. Opportunities exist for dental professionals to create interprofessional relationships with non-dental providers. Relationships with obstetricians/gynecologists and the American Congress of Obstetricians and Gynecologists (ACOG), pediatricians and the American Academy of Pediatrics (AAP) and registered dietitians and the Academy of Nutrition and Dietetics (AND) are key to ensuring good nutrition information is provided to those involved in prenatal and early childhood health care. It is crucial that nutritional education and good eating habits be established early as it is extremely difficult to change eating habits once they are established. Additionally, good nutrition and eating habits are important factors in preventing dental disease especially early childhood caries that can be devastating to the health of young children. Noting that the risk of caries continues across the lifespan and may increase in older adults, it will also be important to work with those who provide health care to adults and elders. In light of the growing need for care of the baby boomer population, it will not be possible to ignore the need for effective preventive measures for this population.

ADA is currently involved in a number of collaborative projects with non-dental providers that provide opportunities to strengthen nutritional initiatives. For example, the ADA continues to collaborate with the AAP Section on Oral Health. Following the success of the ADAF funded program to train Chapter Oral Health Advocates, the ADA continues to work closely with AAP to ensure the importance of oral health remains a priority. ADA also continues its liaison activities with the American Medical Association and is a member of the National Diabetes Education Program.

ADA has also established collaborations with organizations that promote good health practices for children and their caretakers. For example, Sesame Workshop, the nonprofit educational organization behind Sesame Street, in partnership with Sam's Club and MetLife Foundation, has developed [Healthy Teeth, Healthy Me](#), a bilingual (English/Spanish), multimedia outreach initiative. The initiative leverages the power of the beloved Sesame Street characters to motivate children two to five years of age, their parents, and their caregivers, to care for children's oral health. On ADA's consumer Web site, [MouthHealthy.org](#), the section devoted to preschoolers contains the Sesame Street videos, one of which focuses on making good food choices and drinking water.

**Communication/Education:** As mandated by Congress, the *Dietary Guidelines for Americans (DGA)* are developed and released jointly by the U.S. Department of Agriculture (USDA) and the U.S. Department of Health and Human Services (HHS) every five years to ensure the public receives the most current, scientifically sound nutrition advice available. The DGA are *evidence-based* Federal recommendations written for use by policymakers and health/nutrition professionals and are designed to prevent and reduce diet-related chronic diseases, while promoting good health and healthy weight. The DGA are part of the majority of dental schools nutrition curricula and provide a science base for dentists to provide nutritional information to patients.

In addition, the USDA and HHS also develop DGA-based consumer messages and tools for the general public. The DGA was last revised in 2010 and a new icon, "MyPlate," replaced the pyramid icon in 2011. This colorful plate provides consumers an easy visual example of how to dish up proper portions for breakfast, lunch and dinner. The icon also emphasizes ideal portion sizes for fruit, vegetable, grains, protein and dairy food groups. One of the messages accompanying MyPlate recommends drinking water instead of sugary drinks. Consumers and health care professionals can visit [www.ChooseMyPlate.gov](#) to view the icon and dietary guidelines. There are also links to tools such as getting a personalized eating plan, healthy eating tips, weight loss information, menu planning, diet analysis and more.

Launched in June 2012, the ADA's consumer Web site, [MouthHealthy.org](#), provides information about nutrition for all ages from infants to elderly adults including links to "MyPlate."

The ADA, along with 35 other groups in the dental community, formed the Partnership for Healthy Mouths, Healthy Lives and is collaborating with the Ad Council to produce a campaign that encourages good oral health. To raise the awareness of the importance of preventing dental disease, the campaign is designed to increase knowledge of prevention, including brushing with fluoride toothpaste, flossing, good nutrition and seeing a dentist on a regular basis. By capturing the attention of caregivers through catchy public messages, they hope to motivate the public to take the first step toward implementing a lifetime of solid oral health habits, including developing healthy eating habits.

Education plays an important role in changing the behaviors of patients. As mentioned previously, dentists can play a significant role in educating patients about the importance of good eating habits and should be prepared to take on that role. These efforts can help improve and maintain dental health and encourage good overall health. It is important to begin counseling at an early age starting with before the mother gives birth and continue throughout the lifespan. To encourage behavior change, messages to the patient should be positive, emphasizing what *should* be done, rather than what *should not* be done. Dentists may wish to collaborate with registered dietitians when additional assistance is indicated.

**Development of Policy that Promotes Good Nutrition:** Reimbursement for “nutritional counseling” currently suffers much the same fate as reimbursement for tobacco cessation. Parameters of exactly what activities over what time comprise “nutritional counseling” are vague. Published outcomes from nutritional counseling are extremely limited and so companies are unlikely to provide benefits even though a CDT code exists to identify this service. Until issues related to reimbursement for this service can be resolved, it is most unlikely nutritional counseling will become common place.

While the Ad Hoc Committee was not charged with making a recommendation regarding current ADA nutrition-related policy, members were provided all existing ADA nutrition-related policies as background. As discussions continued, members noted that policy, Preventive Health Statement on Nutrition and Oral Health (*Trans.*1996:682), appears to provide substantial support for ADA nutritional activities. This policy can be viewed as Appendix 1.

At its June 2012 meeting, CAPIR was provided an update on the status of the Ad Council Campaign and noted its positive educational messaging. In discussing the “carrot or stick” approach to behavior change, the Council noted that in the past, there have been attempts to legislate taxes on soda in several states that were expected to decrease sales in much the same way increased taxes/price of cigarettes decreases sales. During the CAPIR meeting, the Department of State Government Affairs was able to supply information on recent state efforts to pass this type of legislation. That summary is available as Appendix 2.

**Suggested Strategies:** The Ad Hoc Committee on Nutrition formulated the following strategies for future consideration by the Council:

- Determine how lower level evidence based research, the best science that is currently available, can inform policy.
- Support pilot programs that produce outcomes that could inform further research, legislative strategies and policies.
- Focus on education to change behavior.
- Develop materials to facilitate nutritional education as it relates to oral health (i.e., talking points, brochures, specific oral health information in DGA).
- Start nutrition education early, preferably prenatally, and continue educational efforts throughout the lifespan.
- Collaborate with non-dental providers both on a one-to-one basis and organizationally to increase their knowledge on the importance of oral health and how efforts to provide nutritional education can improve both oral and general health.
- Collaborate with ADEA/dental schools to ensure dentists receive nutritional training that prepares them to discuss nutrition related issues with patients.

- ## 4 Resolutions

6 Supplement Report 03 CAPIR

## Appendix 1

**Preventive Health Statement on Nutrition and Oral Health (1996:682)**

**Resolved**, that with respect to nutrition and oral health, the Association encourage dentists to maintain current knowledge of nutrition recommendations such as the *Dietary Guidelines for Americans*, published by the U.S. Department of Agriculture and the U.S. Department of Health and Human Services, as they relate to general and oral health and disease, and be it further

**Resolved**, that the Association encourage dentists to effectively educate and counsel their patients about proper nutrition and oral health, including eating a well-balanced diet and limiting the number of between-meal snacks, and be it further

**Resolved**, that the Association encourage constituent and component dental societies to work with school officials to ensure that school food services, including vending services and school stores, provide nutritious food selections, and be it further

**Resolved**, that the Association oppose targeting children in the promotion and advertisement of foods low in nutritional value and high in cariogenic carbohydrates, and be it further

**Resolved**, that the Association encourage continued federal support for programs that provide nutrition services and education for infants, children, pregnant women and the elderly, and be it further

**Resolved**, that the Association encourage the appropriate government agencies to prevent the distribution of non-nutritious and highly cariogenic foodstuffs under federal nutrition service programs, and be it further

**Resolved**, that Resolution 27-1973-H (*Trans.*1973:659), Sale of Sugar-Rich Products in Schools; Resolution 28-1973-H (*Trans.*1973:660), Food Product Labeling; Resolution 56-1974-H (*Trans.*1974:687), Amendment to National School Lunch Act and Federal Food Stamp Program; Resolution 24H-1978 (*Trans.*1978:500), Statement on Advertising of Sugar-Rich Products to Children over Television; Resolution 129H-1978 (*Trans.*1978:510), Reference to Sugar Substances in School Textbooks; Resolution 98H-1979 (*Trans.*1979:625), Report to the House of Delegates of Task Force on the Prohibition of the Sale of Confections in Schools; and Resolution 8H-1983 (*Trans.*1983:544), American Dental Association Support of Child Nutrition Programs, be rescinded.

## Appendix 2

**Soda Tax Activity in States**

(2011 &amp; 2012 proposals and status)

State	Proposed	Status	✓ = Distribution of funds for dental purposes
CA <a href="#">AB 669</a>  <a href="#">2011</a>	The legislature's stated intent was to diminish the human and economic costs of obesity and dental disease in California. Would have created a dedicated revenue source for health programs designed to prevent and treat childhood obesity and dental disease. The tax on bottled sweetened beverages and sweetened beverages distributed in this state shall be one cent (\$0.01) per fluid ounce. The fund created would be generally used for obesity issues and general health/activity promotion.	Did not pass in 2011; held over to 2012	20% to coordinate statewide childhood obesity prevention activities and to fund state-level childhood obesity prevention and <b>children's dental programs</b> . This funding shall support programs that use educational, environmental, policy, and other public health approaches that achieve the following goals: improve access to and consumption of healthy, safe, and affordable foods and beverages; reduce access to and consumption of calorie-dense, nutrient-poor foods; encourage physical activity; decrease sedentary behavior; and raise awareness about the importance of nutrition and physical activity to childhood obesity prevention. (Remaining percentages got to obesity prevention)
HI <a href="#">HB 1062</a> <a href="#">HB 1188</a> <a href="#">HB 1216</a> <a href="#">SB 1179</a>  <a href="#">2011</a>	1062 & 1188 would have specified a tax of \$.10 to \$.25 for containers up to 12 ounces or over 12 ounces (respectively). 1216 & 1170 would have created a tax without specific amounts.	Did not pass in 2011; held over to 2012	Obesity prevention
HI SB 2408  2012	Tax on sugar-sweetened beverages and deposit portions of the revenue generated to the community health centers special fund, the trauma system special fund, and the John A. Burns school of medicine medical loan forgiveness program special fund established and funded by additional revenue sources pursuant to this Act.	Failed	Moneys in the special fund shall be used to support the John A. Burns school of medicine medical loan forgiveness program for medical students graduating after May 1, 2013.
HI SB 3019  2012	The purpose of this Act is to establish a tax on sugar-sweetened beverages and deposit portions of the revenue generated to the community health centers special fund and the trauma system special fund.		Distribution (1) community health centers special fund established under section 321-1.65; and (2) the trauma system special fund established under section 321-22.5.
NE LB 753  2012	Provide for sales taxation of soft drinks as prescribed	Indefinitely Postponed	Obesity prevention
RI <a href="#">HB 5432</a> <a href="#">SB 295</a>	A soft drink tax would be set at a rate of one cent (\$0.01) per ounce would be created. The tax would be paid by the distributor.	Pending	Used for public health efforts and programs focused on the goal of eradicating obesity

<a href="#">2011</a>	manufacturer or wholesaler. To be used for public health efforts and programs focused on the goal of eradicating obesity. "Soft drink" means any nonalcoholic beverage...containing sugar, corn syrup or any other high-calorie sweetener... "Soft drink" does not include "diet" or sugarless, low-calorie beverages.		
<b>RI</b> HB 7342 SB 2798  2012	Imposes a sugar-sweetened beverage tax upon every sugar-sweetened beverage, syrup, powder or other base product sold within the state of Rhode Island by a distributor, manufacturer, or wholesaler to a retailer or other purchaser, calculated as follows:  (1) The tax on sugar-sweetened beverages shall be one dollar and twenty-eight cents (\$1.28) per gallon of sugar-sweetened beverage.	Pending	Obesity reduction
<b>TN</b> <a href="#">SB 521</a> <a href="#">HB 537</a>  <a href="#">2011</a>	Would have created a one cent per fluid ounce tax on any person manufacturing, producing, or importing or causing to be imported into this state and selling within this state bottled soft drinks that contain added sugar or caloric sweeteners.	Did not pass in 2011; held over to 2012	Unspecified in bill
<b>VT</b> <a href="#">HB151</a>  <a href="#">2011</a>	Would have imposed an excise tax on every distributor of \$0.01 per ounce upon sugar-sweetened beverages sold in the state. Proceeds are to be used for health-related initiative listed in the bill (dental not specifically listed).	Did not pass in 2011; held over to 2012	1/3 to "Vermont healthy weight initiative fund." 1/3 shall be deposited in the Catamount fund (state health insurance assistance program). 1/3 shall be used to fund the credit in 32 V.S.A. § 9413 and the administration of this chapter.
<b>VT</b> SB 615  2012	Imposes a \$0.01 per ounce upon sugar-sweetened beverages sold in the state.  Imposes an excise tax of \$0.01 per ounce of syrup and powder sold in the state.		✓  Deposits 1/3 of collections into the Vermont oral health improvement fund (that would have been created under this bill) to: (1) support the Medicaid dental reimbursement rates; (2) support the VT dentists loan repayment program (3) support the Head Start and school-based Tooth Tutor program administered by the department of health; (4) support costs incurred by entities that own or control water systems in complying with the fluoridation requirements in this bill (5) support the Baby Bottle Tooth Decay education program administered by the department of health.