Statement of the

American Dental Education Association (ADEA)
and the
American Association for Dental Research (AADR)

Before the
House Energy and Commerce Committee

Presented by
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Introduction

Mr. Chairman and members of the Committee, I am Dr. Nick Mosca, Clinical Professor of Pediatric and Public Health Dentistry at the University of Mississippi School of Dentistry and Dental Director for the state of Mississippi. I am a member of the American Dental Education Association (ADEA) and the American Association for Dental Research (AADR). This morning I am testifying on behalf of both organizations.

The ADEA represents over 120 academic dental institutions as well as all of the educators, researchers, residents and students training at these institutions and AADR represents over 5,000 individual members and 100 institutional members. The joint mission of ADEA and AADR is to enhance the quality and scope of oral health, advance research and increase knowledge for the improvement of oral health, and increase opportunities for scientific innovation. Academic dental institutions play an essential role in conducting research and educating and training the future oral health workforce. These institutions provide dental care to underserved low-income populations, including individuals covered by Medicaid and the State Children's Health Insurance Program.

I thank the committee for this opportunity to testify about access to oral health care, the role academic dentistry plays in providing care for underserved populations and the role we play in educating a competent and diverse oral health care workforce for the nation.

Preventive Care is Essential to Eradicate Oral Health Disparities and Contain Costs

Americans spend millions of dollars annually in treatment of dental caries (cavities) and tooth restoration. Despite tremendous improvements in the nation's oral health over the past

decades, the benefits have not been equally shared by millions of low-income and underserved Americans.

As the Surgeon General's report on oral health in America told us seven years ago, there are "profound and consequential oral health disparities within the population," particularly among racial and ethnic minorities, rural populations, individuals with disabilities, the homeless, immigrants, migrant workers, the very young, and the frail elderly." At the time of publication of the Surgeon General's Report there were 108 million Americans lacking dental insurance, of which 23 million were children.

Children in households below 200 percent of poverty have three times the tooth decay of children from affluent homes. Their disease is more advanced and is less likely to be treated. Eighty percent of untreated dental caries (tooth decay) is isolated in roughly 25 percent of children. The majority of these children are from low-income and other vulnerable groups—the same groups that rely upon public health programs for their care. Most adults, particularly as they age show signs of periodontal or gingival disease. Fourteen percent of people age 45 to 54 have severe periodontal disease and that number grows to almost a quarter (23 percent) for people age 65 to 74. Tragically one-third of adults (30 percent) are completely toothless (edentulous).

Access to oral health care can be a matter of life and death. Those of us who read the Washington Post were reminded of that recently with the untimely death of Deamonte Driver, a 12-year-old boy with an abscessed tooth, part of an uninsured and sometimes homeless family whose Medicaid coverage had lapsed. Deamonte's tooth infection spread to his brain. After two brain surgeries and six weeks in the hospital (and tens of thousands of dollars in medical expenses), he died. A week ago USA Today reported that a routine dental visit revealed a cancerous tumor in the mouth of North Carolina football coach Butch Davis. Coach Davis is now undergoing chemotherapy for non-Hodgkin's lymphoma. His access to oral health care, in combination with dental insurance played a critical role in saving his life.

America's most prevalent infectious disease is dental decay (caries) for all ages. It is five times more common than asthma and seven times more common than hay fever in children. Early childhood caries is dental decay found in children less than five years of age. It is estimated that 2 percent of infants 12-23 months of age have at least 1 tooth with questionable decay whereas 19 percent of children 24-60 months of age have early childhood caries in the U.S.[1]

Preventative care is essential to contain costs associated with oral health care treatment and delivery. Children who have early preventive dental care are more likely to continue using preventive services. Those who wait to visit a dentist are more likely to visit for a costly oral health problem or emergency. The average cost for a dental visit before age one was $262. This doubled to $546 when a child's first visit wasn't until ages four to five.[2]

Dental caries is a chronic, infectious disease process that occurs when a relatively high proportion of bacteria within dental plaque begin to damage tooth structure. If caries can be diagnosed before irreversible loss of tooth structure occurs, it can be reversed using a variety of approaches that "remineralize" the tooth. In addition to improved diagnostics, researchers are

[1] "Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs," Matthew F. Savage, DDS, MS, Jessica Y. Lee, DDS, MPH, PhD, Jonathan B. Kotch, MD, MPH, and William F. Vann, Jr., DMD, PhD, Pediatrics Vol. 114, No. 4, October 2004.
[2] Ibid

working to develop a vaccine to prevent tooth decay while others use new methods to specifically target and kill the decay-causing bacteria.

Academic Dental Institutions and Access to Care

U.S. academic dental institutions (dental schools, allied dental programs and postdoctoral/advanced dental education programs) are safety net providers increasing access to care. These institutions are dental homes for a broad array of racially and ethnically diverse patients including low-income non-elderly and elderly individuals; migrant individuals; homebound individuals; mentally, medically or physically disabled individuals; institutionalized individuals; HIV/AIDS patients; Medicaid and SCHIP children and uninsured individuals.

All U.S. dental schools operate dental clinics and most have affiliated satellite clinics where preventative and comprehensive oral health care is provided as part of the educational mission. All dental residency training programs provide care to patients through dental school clinics or hospital-based clinics. Additionally, all dental hygiene programs operate on-campus dental clinics where classic preventive oral health care (cleaning, radiographs, fluoride, sealants, nutritional and oral health instruction) can be provided 4-5 days per week under the supervision of a dentist. All care provided is supervised by licensed dentists as is required by state practice acts. All dental hygiene programs have established relationships with practicing dentists in the community for referral of patients. Millions of dollars of uncompensated care are provided by academic dental institutions each year.

As major providers of services to underserved populations, academic dental institutions also play a major role in enhancing private sector initiatives that support expanded access to dental care. They support school-based sealant programs that reduce the incidence of tooth decay in children; and they evaluate the dental workforce capacity needed to adequately serve those in Medicaid, Ryan White HIV/AID clinics and other public assistance programs.

Educating the Nation's Oral Health Care Workforce

Oral health care is important for all Americans including those living in inner cities and in rural underserved areas. There are presently more than 3,400 designated dental health profession shortage areas, in which 45.3 million people live. It is doubtful that many of these areas can financially support a dentist or attract a dentist by virtue of their infrastructure or location. But the issue remains. There are unserved and underserved communities and populations, as well as a growing desire in society to have equitable access to health care and dental care for all. The challenge to dentistry is not only to expand the capacity of the dental workforce; it must also improve its distribution and access to oral health care. In order to achieve these objectives it is the mission of academic dental institutions to educate and train the U.S. dental health care workforce.

<u>Predoctoral Dental Education</u>

Upon successfully completing dental school and passing a state licensure exam graduates may enter private practice as general dentists. Graduate also have the option to pursue advanced and specialty training.

At the present time about 4,500 predoctoral dental students graduate annually after four years of dental school. The high water mark for dental student enrollment occurred in the late 1970s with 6,300 students. Enrollment increased during the 1960s and 1970s

due to surges in both the baby boomers coming of college age and the percent of college age adults enrolling in college. Also, there was broad support for expanding the number of health care providers during that time which led to federal student loan and scholarship programs, as well as federal construction and capitation grants to schools to support enrollment increases. Then during the late 1970s and through the 1980s there were declines in enrollment which can be attributed to a strongly voiced perception of an oversupply of dentists, periods of economic inflation and stagnation, and termination of federal support for further expansion in the numbers of health care providers. During the mid-1990s, applicants to dental school increased as dentistry was once again perceived to be a challenging and financially rewarding profession. However, enrollment increased only slightly. It should be noted that there is limited capacity within the current dental education infrastructure to accommodate much of an enrollment increase. And until recently, there was not support or need to do so nationally.

At the present time there are 56 U.S. dental schools in 34 states, the District of Columbia and Puerto Rico. Growing demand for dental care in certain areas of the country has precipitated the opening of six new dental schools. In 2003 the Arizona School of Health Sciences, the University of Nevada Las Vegas in 2002, and the Nova Southeastern University in Florida in 1997. In near future East Carolina University in Greenville, North Carolina plans to open a dental school with a focus on rural dentistry. The school plans to operate 10 student dental clinics in under-served communities throughout the state enrolling 50 students per class. Midwestern University in Glendale, Arizona will open a dental school in August 2008 with an enrollment of 100 students per class. The dental school is part of Midwestern's expansion plan to address the state of Arizona's health care workforce shortages. Western University of Health Sciences in Pomona, California plans to open a dental school in the next few years. The University is in the preliminary phase of the accreditation process.

Prior to these openings, significant growth took place from 1960-1978 with the number of dental schools increasing from 47 to 60. This increase of 13 was during a time of federal construction grants and a widely perceived need to expand the number of all health care professionals, including dentists. Between 1986-2001, seven dental schools closed, all private or private/state-related dental schools.

Dental Residency Training

Approximately 2,800 new graduates and other dentists who have been in practice choose to specialize or advance their training in general dentistry by enrolling in dental residency training programs. There are nine recognized dental specialties: oral surgery, oral radiology, oral pathology, orthodontics, endodontics, periodontics, pediatric dentistry, dental public health as well as two programs in general dentistry, general practice residency and advanced education in general dentistry. Dental residency training programs last from a minimum of 14 months for Dental Public Health up to maximum of 54 months for oral surgery. Dental residency programs increase access to oral health care for a broad array of patients. Dentists may not practice a dental specialty without having successfully completed the required training.

In 1995, the Institute of Medicine called for the creation of a number of graduate dental education residency positions sufficient to accommodate all graduates by 2005. In 1999, the Journal of Dental Education published a series of articles in a special issue that set forth a focused and compelling rationale for a mandatory, post-graduate year of

dental residency education (PGY-1). The most recent call for a PGY-1 was in December 2006 at the ADEA Summit on Advanced Dental Education. Delaware has long required a residency before dentist could begin practice in the state. Beginning this year the state of New York requires a PGY-1 for initial licensure.

Allied Dental Education

There are about 300 dental hygiene programs in all 50 states and the District of Columbia. Most dental hygiene programs grant an associate degree, others offer a certificate, a bachelor's degree, or a master's degree. Dental hygienists rank among the fastest growing occupations. Each state has its own specific regulations regarding dental hygiene responsibilities thus services provided varies from state to state. Nearly 13,900 dental hygienists graduate annually.

There are 272 dental assisting programs located in 47 states and Puerto Rico. Dental assistants enhance the capacity of a dental office to treat patients by assisting dentists with a variety of treatment procedures. About 8,000 dental assistants graduate each year.

Eight hundred students graduate annually from the 20 dental laboratory technology programs located in 16 states. These individuals create replacements for natural teeth and corrective devices; fabricate dentures, bridges, crowns and orthodontic appliances and work with a variety of materials such as waxes, plastics, precious and non-precious alloys, porcelains and others to fabricate dental restorations and tooth replacements.

Medicaid and SCHIP

More than nine million children lack medical insurance and 23 million children lack dental insurance. Medicaid plays a critical role in children's access to dental services. In fact, Medicaid pays for 25 percent of all dental expenses for children under 6 years of age. Also, Medicaid covered 66 percent of the dental expenses incurred for all people with public insurance.

All 25 million children in Medicaid under age 21 are eligible for needed dental care through the Early Periodic Screening, Diagnosis and Treatment program (EPSDT). Dental services were among the first three preventive health care services included in EPSDT. Although all children enrolled in Medicaid qualify for EPSDT services, less than one in four children on Medicaid receive them.

State Medicaid programs are required to ensure that dental services are available and accessible and to provide services if a problem is identified that requires treatment. States must also inform Medicaid-eligible persons about the availability of EPSDT services and assist them in accessing and utilizing these services. Services include regular screenings and dental referrals for every child at regular intervals meeting reasonable standards of dental practice established by states in consultation with the dental profession. States must provide, at a minimum, services that relieve pain and infection, restore teeth, and maintain dental health.

The State Children's Health Insurance Program (SCHIP) plays a critical role in providing access to dental care for covered children. Although states have the option to include dental coverage (presently all states have some level of dental benefits) the fact that they do so is a significant factor in a parent's decision to enroll their children in SCHIP.

As Congress deliberates the reauthorization of the SCHIP, ADEA/AADR urges Congress to immediately enact legislation that would enhance SCHIP insurance coverage and enhance access to dental care. We recommend that Congress enact following recommendations to improve the system of care: 1) Establish a federal guarantee for dental coverage in SCHIP; 2) Develop a dental wrap-around benefit in SCHIP; 3) Facilitate ongoing outreach efforts to enroll all eligible children in SCHIP and Medicaid; and 4) Ensure reliable data reporting on dental care in SCHIP and Medicaid.

Dental care for adults under Medicaid is optional. As a result, many states often reduce or eliminate funding for adult dental programs during difficult economic times[3]. Today, most states have caps or limits on spending for adult oral health and dental services. Forty-one states offer *only emergency care*. As states begin to recover from the recent economic recession, some are reinstating *limited* oral health and dental services for adults; however, only a relatively few states provide *comprehensive* adult services. For many Medicaid-eligible adults this is the only insurance coverage they have for oral health and dental care.

Federal Programs That Help To Address Oral Health Workforce Issues

The Dental Health Improvement Act, a federal grant program for states, awarded the first 18 grants to states last October to help develop innovative dental workforce programs. The first grants are being used for a variety of initiatives including: increasing hours of operation at clinics caring for underserved populations, recruiting and retaining dentists to work in these clinics, prevention programs including water fluoridation, dental sealants, nutritional counseling, and augmenting the state dental offices to coordinate oral health and access issues.

The Title VII General and Pediatric Dentistry Programs are essential to building the primary care dental workforce are effective in increasing access to care for vulnerable populations including patients with developmental disabilities, children and geriatric patients. These primary care dental residency programs generally include outpatient and inpatient care and afford residents with an excellent opportunity to learn and practice all phases of dentistry including trauma and emergency care, comprehensive ambulatory dental care for adults and children under the direction of experienced and accomplished practitioners.

The Centers for Disease Control and Prevention Oral Health Program expands the coverage of effective prevention programs by building basic capacity of state oral health programs to accurately assess the needs in their state, organize and evaluate prevention programs, develop coalitions, address oral health in state health plans, and effect allocation of resources to the programs. CDC provides technical assistance to states that is essential to help oral health programs build capacity.

Congress designated dental care as a “core medical service” when it reauthorized the Ryan White Modernization and Treatment Act in 2006. Seventy-five percent of the funding for Titles I and II must be devoted to core medical services. This should result in many more afflicted patients receiving the dental care they need. The Dental Reimbursement Program provides access to quality dental care to people living with HIV/AIDS while simultaneously providing educational and training opportunities to dental residents, dental students, and dental hygiene students who deliver the care. The Dental Reimbursement Program is a cost-effective federal/institutional partnership that provides partial reimbursement to academic dental

institutions for costs incurred in providing dental care to people living with HIV/AIDS. The Community-Based Dental Partnership Program fosters partnerships between dental schools and communities lacking academic dental institutions to ensure access to dental care for HIV/AIDS patients living in those areas.

The under representation of minorities poses a challenge to the U.S. health care workforce, including dentistry, especially as immigration trends contribute to increased numbers of minorities in the population. Title VII Diversity and Student Aid programs play a critical role in helping to diversify the health professions student body and thereby the health care workforce. Of paramount importance are the Health Careers Opportunity Program, the Centers of Excellence and the Scholarships for Disadvantaged Students. These programs are key drivers in recruiting and retaining students in the health professions. For the last few years these grant programs have not enjoyed an adequate level of support to sustain the progress that is necessary to meet the challenges of an increasingly diverse U.S. population.

Academic Dental Institutions Recommendations

Oral disease affects individuals, families, the community and society. Poor oral health can lead to pain and infection, missed work or school and disruptions of vital functions such as speech and eating, and other productive activities. Oral disease not only poses a risk to general health it can complicate other existing medical conditions.

While dental care demands are higher than many other health care demands, many people in the U.S. do not receive basic preventive dental services and treatment. Most oral diseases are preventable if detected and treated promptly. Yet millions of Americans face unacceptable conditions in oral health living daily with pain and disability without treatment. The major reason for not obtaining dental services is financial. Since few oral health problems in their early stages are life-threatening, people often delay treatment for long periods of time. Often, it is hospital emergency rooms to which they turn once they can no longer stand the pain or their condition has worsened to the point where they can no longer postpone treatment.

ADEA/AADR urges Congress to adopt our SCHIP recommendations as set forth in this testimony that will greatly enhance access to vital preventive and restorative oral health care services: 1) Establish a federal guarantee for dental coverage in SCHIP; 2) Develop a dental wrap-around benefit in SCHIP; 3) Facilitate ongoing outreach efforts to enroll all eligible children in SCHIP and Medicaid; and 4) Ensure reliable data reporting on dental care in SCHIP and Medicaid.

Furthermore, we urge Congress to ensure adequate funding of the federal programs outlined above, namely Medicaid and SCHIP, the Dental Health Improvement Act, Title VII General and Pediatric Dentistry Programs, the Centers for Disease Control and Prevention Oral Health Program, the Ryan White Modernization and Treatment Act and the Title VII diversity and student aid programs which include the Health Careers Opportunity Program, the Centers of Excellence and the Scholarships for Disadvantaged Students.