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Dental Health: Nurturing the Health Care System's Neglected Stepchild

Kaiser Family Foundation
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ED HOWARD, EXECUTIVE VICE PRESIDENT, ALLIANCE FOR HEALTH REFORM: Good afternoon. My name is Ed Howard and I am with the Alliance For Health Reform. And on behalf of our Congressional Leaderships Senators Rockefeller and Collins, our Board of Directors, I would like to welcome you to this Briefing On Oral Health. Our partner in today's program is the Kaiser Commission on Medicare, Medicaid and the Uninsured, a Project of the Kaiser Family Foundation which I am sure most of you know as the one of the most respected policy voices in the health reform debate and all issues relating to care for vulnerable populations. You are going to hear from Diane Rowland representing both the Commission and the Foundation in a moment.

We spend a lot of time at the Alliance focusing on how to overcome the substantial problems facing the 47 million people who do not have health insurance in this country. But by some estimates the number of people without dental insurance is two to two and a half times that number. If there is one thing we know for sure it is that oral health affects overall health and well-being. We know there are profound disparities in oral health and access to care among different groups in this country. I should add at this point that both Senator Collins and Senator Rockefeller have taken a special interest

in this topic. Senator Collins is especially interested in the shortage of dental professionals in rural areas like those in some parts of Maine. Senator Rockefeller has said many times that seeing the huge dental problems among the poor kids and adults in the little West Virginia town where he was a Vista Volunteer many years ago was one of the most moving experiences of his life.

As I said, co-hosting today is the Kaiser Commission on Medicaid and the Uninsured. They have done a great deal of work on this issue including, by the way, issuing two new publications. Both of them are in your packets on this topic. Here on behalf of the Commission and the Kaiser Family Foundation today and Chairing our moderation duties is one of the country's top health policy analysts, Kaiser Executive Vice President and Commission Executive Director, Diane Rowland. Diane?

DIANE ROWLAND, KAISER COMMISSION ON MEDICAID AND THE UNINSURED: Thank you, Ed. It is always a pleasure to be here and share the podium with Ed and to be part of an Alliance Briefing. I am especially pleased to be at this Alliance Briefing because it is a topic they we often do not cover. Highlighting the dental issues today I think is a very important contribution not only to our examination of how current programs work but especially as we begin a discussion

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about health reform and moving forward on broader health care coverage. What does that coverage mean and where will dental benefits fit into it? I think is a most timely topic for us to consider.

Now certainly what we know is that one of the ways that we use our Alliance Briefing is to try and track what has happened to policy recommendations and policy changes over time. Certainly the Surgeon General's report on oral health in 2000 was a real wake up call for the need to really address oral health issues as a nation outlining some of the key issues and challenges. It is an integral part of both physical and social healths. Sometimes we think as dental benefits as outside of those but it is actually very much a part. It impacts school attendance and employability for adults.

Ed mentioned Senator Rockefeller's comments. I remember so clearly him talking about, as a Vista Volunteer, trying to get people jobs in West Virginia and realizing they had poor nutrition. They could not open their mouths to really let anyone see the inside of their mouth when they were on job interviews which really tended to leave them trapped in their poverty that they were living in.

I think it is very important part of our recognition that low-income populations bear a disproportionate burden of dental disease. Poor children today are twice as likely to

untreated tooth decay as other children. There is a lack of dental coverage across the country, however. Over 100 million as Ed alluded to, lack dental benefits. In some of the work we do looking at employer sponsor benefits, we see that only 44-percent of those firms that offer benefits to their workers offer dental benefits as part of their health package.

We know that low provider participation in Medicaid has created access problems for the children who have dental coverage through that program. They are not getting the kind of services that they need. And there has been a really low awareness among many of the importance of oral health and the need for an oral health infrastructure and as Senator Collins has supported, a broad workforce.

It is a particularly important when we think about children as we probably enter into the next reauthorization debate over the SCHIP Program to look at the importance of dental benefits for that population. Today if you look at the use of services by children you that 78-percent of those with insurance actually access dental visits compared to only 48-percent of the uninsured so that it is affecting how people use the system. As we look at the role of public coverage clearly Medicaid covers a very comprehensive dental benefit especially under the Early Periodic Screening, Diagnosis and Treatment or EPSDT portion of the program and covers one in four of American

children today. But we know that low provider participation there and lack of enrollment of many children in the program who are eligible really does compromise the ability of low-income children to get the services that they need.

We do know also that as we look at the SCHIP program it has been less comprehensive in terms of its dental coverage to children in Medicaid and some coverage is provided for children in all but one state. But this may be an issue that really should be looked at in the reauthorization debate again.

Also when we think about children the coverage is of course far broader than that for adults where Medicaid coverage of dental benefits for adults is an optional benefit. It is often the first on the chopping block when the economic downturns occur, as they are now. Over half of the states provide no or emergency only dental services. So it is not even a widely covered benefit for the adults on the program.

So there are many key challenges ahead that I think we are going to talk about today to both broaden coverage of dental care. Look at how the SCHIP benefit packages arrayed. Try and look at issues around providing coverage for adults including dental care as a part of what we talked about in health care reform and not as a side issue. As I mentioned now twice, increasing provider participation in Medicaid and improving the oral health workforce and delivery system are

challenges that go along with the coverage challenge so that we can really start to talk about being a nation that actually takes care of one of the most important components of our body, our teeth. Thank you.

ED HOWARD, EXECUTIVE VICE PRESIDENT, ALLIANCE FOR HEALTH REFORM: Thank you, Diane. Just a couple of logistical notes, by Monday you will be able to view a Web cast of this session on Kaiser Network.org and a few days after that you will be able to review a transcript of both at Kaisernetwork.org and at our Web site allhealth.org. All of the materials in your packets are posted on both of those Web sites too so that you can share them with your colleagues.

If you have been to any of these briefings before know that there is a green question sheet card that you can fill out when we get to that part of the program. There are also three floor microphones you can use to ask questions in person and there is a blue evaluation form that we would appreciate your filling out at the appropriate time. So take a moment to shut your cell phone off or turn it to vibrate.

I would like to introduce the beginning of what I think is a very impressive array of Panelists today to help us come to grips with this issue.

Leading off is Doctor Harold Goodman who is the Maryland State Dental Director. He is dentist himself. Nobody

in this area forgets the tragic case of Deamonte Driver whose untreated dental problems last year led to his death.

Harry Goodman has led the efforts by the Maryland Executive Branch to improve the oral health situation for low-income kids in the state to make sure that that tragedy is not repeated. We have asked him to share some of that experience with us today.

Harry, thank you for coming down.

HARRY GOODMAN, DIRECTOR OF ORAL HEALTH, STATE OF MARYLAND: Thank you very much for inviting me. Good afternoon everyone and it is a pleasure to be here. I am going to really be speaking to the Maryland case and the context of the life and death of Deamonte Driver. I think this story is a compelling one. So this is basically is a case study. This will also be case study of my getting through this in eight minutes.

Maryland has been called American in miniature so I really want to emphasize that Maryland is really not the exception here. We are really the rule in terms of this situation of oral health in a particular state. Go to the next slide please.

Deamonte Driver grew up in Prince Georges County, Maryland. Maryland is one of the five wealthiest states in the country. He came from a low-income family. It is a family

that basically always had medical insurance through the Medicaid Program. They always had access to a Primary Health Provider but basically never to Primary Dental Provider.

I think that is key when you look at state Medicaid throughout the county. There is a well documented case of the family trying to find a dentist for one of the five boys and to little avail despite the fact there was a full array of dentists. There are 26 or 27 in the local area alone on this one Managed Care Panel.

We will talk about Maryland in the context of Deamonte Driver's life. He was probably born in the mid '90s somewhere around '95. At that time Maryland indeed was ranked as one of lowest in the country in terms of access to care by ADA analysis. No impressive dental rates have been increased since the 1970s.

In 1997 we went to a managed care program called Health Choice where we went to seven managed care organizations subcontracting to three dental venders. It is a very complicated system. In 1998 the office of Oral Health, my office, became part of State law. I think that is very critical because up until then there was nobody at the table asking what about dental? A dental director can do that in one recommendation. Certainly every state in this country should

have a viable strong state office of Oral Health for the State Dental Director.

You can see the data that despite a wealthy state, over half of Head Start kids had untreated tooth decay and about a third of the school children, in the most recent survey in 2006. In 1998 when the Office of Oral Health became instituted to work with the Medicaid Program to strengthen it and some very, very key legislation was passed to increase rates. Finally by 2003 we actually had a significant rate increase.

We also developed a very, very significant loan assistance repayment program to dentists, an incentive program to help treat Medicaid children. As you can see by the most recent data that about 29-percent have access to one dental service of any type in the past year and far fewer have had any restorative treatments such as fillings. You can see that about 19-percent of dentists participated in Medicaid with even a smaller proportion actually having significant participation by the $10,000.00 in billings.

By February 2007 just prior to Deamonte's death most Medicaid fees in Maryland were still in the 25th percentile and many below the 10th percentile. You can see that the public health infrastructure was wanting with only half of the health departments with a dental program. In the federally qualified

health centers, most of them had one but most were situated in Baltimore City.

We had a scope of practice issues with dental hygienists not being able to practice what they have been taught to do in public health settings because they needed a dentist on site. We have physicians not routinely assisting in oral health assessments. And we have a mal-distribution of care with regards to dentists and dental hygienists supply, specifically, specialists. And we also have tremendous recruitment problems in the public health sector to get dentists and hygienists.

What happened next, of course, is very emblematic of what happens. Oral disease is the number one chronic disease in children, worldwide, really. One of the problems is if the dental disease is in the forehead or on the tip of your nose someone would say, what is wrong? There is something there and we need to something. But unfortunately it is hidden in the recesses of the mouth. If someone does not complain which is often the case unless there is pain. When there is pain it is too late. If no one is looking you have a recipe for disaster and this was truly a disaster in a literal sense.

It does not happen all the time but there are more cases than Deamonte Driver out there, by the way. But with Deamonte, basically no one looked until he finally went to his

physician with severe headaches. The physician is also key because we need physicians to also be looking in mouths early on. And that's a key issues as well. Finally found the problem. First diagnosis was sinus infection and eventually a brain infection. It went to his brain, after two brain surgeries, and had seizures, six weeks in the hospital. And all he needed was that one tooth extracted. At a cost of about $250,000.00 to the state, Deamonte Driver had all this care. The cost could have been less than a $100.00 for that extraction and if we had been practicing good prevention, far less.

Tragedy. This is a tragedy in the greatest sense of the word. It is always tragic to lose a child. It is always tragic that a child maybe has an issue from cancer or what-have-you, which is just an unlucky roll of the dice. This case is so preventable and that is what defines the word tragic in this case. He died of a brain infection eventually. He was failed both on the front end by lack of good preventive and education services. And certainly on the back end by the fact that he could not get dental treatment. Laurie Norris called him the canary in the coalmine.

The legacy of Deamonte Driver is that a light is beginning to shine in Maryland. Secretary John Colmers basically conveyed a very serious minded Dental Action

Committee which left their egos at the door and said do not talk about all the problems. Do not talk about the whining. Let us come up with solutions and basically came up with seven main recommendations. All were eventually brought before Secretary Colmers and Governor O'Malley and supported. They were supported in Governor O'Malley's budget to the tune of about 16 million dollars despite a very, very tough budget. We got tremendous support from our federal legislators and our state legislators.

The seven main recommendations really are one. We increased the dental reimbursement rates to the ADA standard of 50th percentile. That is the median fee charged by an area dentist in the region and it is going to be the first of three incremental increases. The second is a single payer program to get rid of the confusion with the seven NCOs with the three dental vendors. We are going to have one dental vendor for provider and patients to go to. Increase the dental public infrastructure to the tune of two million dollars a year and that means grants out to develop the public health infrastructure. Expand the role of dental hygienists in public health clinics so that they do not need a dentist now to be on site and even be there to first see the patient. Pediatric dental training of physicians and dentists are very, very key not just for pediatricians, but even for general dentists to be

able treat young children. Oral health screenings required for school entrance and to develop a unified social marketing campaign. We are going to need your help as well for federal funding. The University of Maryland Dental School, which plays a tremendous role as a partner in all of this also has asked for funding from the CDC.

In terms of federal assistance to the states I am going to leave some of that the discussion of the bills actually to my more accomplished colleagues on this panel. I will say that we need funding for the public health infrastructure. We need funding for salary support to help recruit dentists and hygienists. We need more federally qualified health centers and we need also help again to develop social marketing and educational campaigns so that we can teach the public about the importance of oral health. As well as be able to train physicians and train dentists to be able to link their oral health services to the public.

My final thoughts: Number one we have reference materials. We have a Dental Action Committee Report. I believe it is in your handout the Executive Summary. I really encourage you to look at it. It is a very, very comprehensive report. We are very proud of it.

I also want to give my thanks to Secretary Colmers who has taken this personally as have I about the death of Deamonte

Driver. We have not let this rest. I also certainly want to thank Governor O'Malley for his support again. In a year where we have had a budget shortfall, he put all this money into oral health and is really swimming up stream.

I also want to give special thanks to our Maryland State Legislators, State Senator Thomas Middleton and Delegate Peter Hammen. Thomas Middleton is from Charles County in Maryland, Peter Hammen from Baltimore City. A special thanks to Senator Cardin and even more special thanks to Congressman Elijah Cummins, who has been there every step of the way and also has taken this death personally, as a personal affront to him.

I either go to Yogi Berea or Plato to make things clear. I will go Plato this time and basically state that this is a child that actually did see the darkness. It is tragedy in a true sense but on a different sense on a global level if we do not take advantage of the light that has come out of this tragedy. If we run away from it, if we ignore it then we really missed a tremendous opportunity and that would also be a real tragedy.

Thank you very much. [Applause] Thank you very much.

ED HOWARD, EXECUTIVE VICE PRESIDENT, ALLIANCE FOR HEALTH REFORM: Now we are going to hear from Burt Edelstein who is a pediatric dentist. He is a professor of Dentistry and

Health Policy at Columbia University, chairs a Board of the Children's Dental Health Project, several publications of which are in your materials. He has done stints on the hill and in the Executive Branch here in Washington and he is one of the leading experts in the country in oral health and we are very pleased to have you with us here today. Burt?

BURTON EDELSTEIN, CHAIRMAN, CHILDREN'S DENTAL HEALTH PROJECT: Thank you, Ed. Thank you, Ed for the Alliance focusing their attention on this and Diane for Kaiser focusing their attention on this issue. It is very welcomed and very timely. I was charged to essentially answer two questions. Is Deamonte the canary in the coalmine in fact? And how do we place the experience of this child's life and death in the broader context of pediatric health policy, or health policy more generally?

I have three perspectives to share with you today. The first is that of pediatrics. The second is that of pediatric oral health policy as a policy issue. And the third that of the work of the Children's Dental Health Project and the niche that it occupies here in this town.

So first, the singular reason why you must, each of us must focus on children's oral health specifically is because everything that goes wrong in people's oral health throughout a lifetime is initiated during the pediatric years. Tooth decay,

which as you heard Harry mention is the single most prevalent chronic disease of childhood in the U.S. It is five times more prevalent then asthma. It is established before age – and I like to pause here for people to ponder what the next word is because it is often a surprise to people. But pediatric dental caries, early childhood caries, is established as a disease process before age two. So anything that we do after age two is no longer primary prevention.

Gum disease, the single cause of tooth loss the greatest cause of tooth loss in the U.S. is established as a disease process during late childhood and early adolescence. Oral cancer, the third major disease of the oral cavity, has all of its determinates and the risk exposures established by the time young adulthood is established.

The dynamic growth and development of the face and mouth all happen during the growing periods of childhood, along with the age at which there is the highest incidence of injury, both intentional and unintentional injury, more so than at any other time of life.

If we are going to be serious about life long, life course improvements in oral health the only time to nip it in the bud is early on. and the trajectory, once established, can be quite negative and impactful and consequential in children's lives as they become adults.

The second perspective relates to how children's oral health is actually a health policy issue and an issue therefore for your consideration. There I would like to divide the focus into two halves, the bad news and the good news.

The bad news is that among all health policy issues that you address in your work, dental is the best example of the worst case in too many incidences. Whether we are talking about access or Medicaid performance or workforce adequacy or consequences of a preventable disease or failure to prevent a preventable disease or disparities or safety net adequacy or almost any such issue, dental is one of the most outstanding problems.

Let me just give you some examples. Disease burden, a quarter of all preschoolers already have visible cavities, half by the time they enter first grade. Medicaid performance, the very same kids, 80-percent of whom get a medical visit in a year, only 30-percent get a dental visit in a year. If it can be done on the medical side, it can be done on the dental side.

Uninsured, as Ed mentioned, there are two and a half times more kids without dental insurance than without medical insurance.

Consequences, they are not just the pain that we talked about earlier and an occasional tragedy like the one we have already discussed but how about the consequences when these

children are now young adults. 42-percent of all new military recruits cannot be deployed because of dental problems. Until they get their teeth fixed they are not deployable and once deployed the single most common reason that people come off active duty in their duty stations is because of dental emergencies.

Safety net, less than half of the community health centers, that backbone of the safety net, even have dental programs.

Disparities, children with the greatest needs have the least access. So whatever the policy issue, it is one that you have the opportunity to attend to.

But the good news, the really good news is that dental disease is virtually 100-percent preventable and if not prevented in the first place than it is almost 100-percent controllable or manageable. Tooth decay in particular is an infectious disease. It is diet dependent, it is fluoride protected and yet what we know about the science of the disease and the science of behavioral interventions has not been well employed to reduce this disease and its consequences.

There is in public health the common determinate approach to child health and well-being and it fits perfectly because through parental empowerment, healthy environments, the support of safe and health promoting opportunities for

children, we truly stand a chance as a community, as educators, as day care people, as school authorities, as health officials everybody where children live, play and learn there is an opportunity to promote the conditions under which children will not experience the kind of disease that we have already become to familiar with.

We need to redefine early childhood tooth decay prevention and control. Needed is public policy support to make that happen, so that dental and dental hygiene professionals, pediatricians, Head Start, and child workers all of the people that come in contact with children can promote oral health. Much of this thinking has already been legislated thanks in part to the hard work of Senator Rockefeller and so many others. There are seven distinct oral health provisions in the CHIPRA Act. We will see it again and we anticipate that there will be real energy by all of us here on this panel to again ensure that those dental provisions show up in the SCHIP Re-Authorization. But many of those ideas that I just mentioned are already evident in such legislation.

Early intervention, there is a requirement in CHIPRA that parents have their first advice about preventing dental disease at the time of birth. Inclusion of required dental benefits right now in SCHIP Dental is optional and as Diane

mentioned, all but one state have reasonably robust dental programs.

Assurance that the benefit does cover indeed basic needs, inclusion of oral health reporting, and etcetera, so many of these things have already been legislated. The legislative language is there, it just needs to see the light of day.

At least one key element was not included and that was the wrap-around coverage that would address the issue that Ed mentioned, which is that disparity between the coverage for medical services and the coverage for dental services. Also needed, according to the Surgeon General's workshop, are attention to those polices and programs that support systems of care.

I would like you to consider for a quick moment the mouth and its orphan status. Think about the functions of the mouth. Respiration, we breath through it. Digestion, we eat through it. Sensation, we taste through it. Communication, we speak through it. Protection and immunity, our body is protected from exposure from the outside world through it. These are essential medical components of our health and our well-being and the distinction between policy on oral health and policy on general health is just one that is not tenable.

Whatever you do to consider the health and welfare of children needs to be considered for dental as well.

Let me just finish up with a third perspective, a quick prospective on the Children's Dental Health Project and an announcement that I am happy to make. I wanted to note that the CD in eight days will become the National Oral Health Policy Center through a cooperative agreement with the Maternal and Child Health Bureau. And all of the effort that we have made for the last 11 years to provide information and technical assistance to each of you in the community that either make policy or support those who make policy will be able to be ramped up even more. We look forward to assisting you in any way.

To sum up, let me just restate that too many children suffer too much, too often from a completely preventable set of diseases. Policy action is now needed to improve the financing, to ensure competent, adequate and available workforce, to bolster the safety net and most of all to empower federal programs tightly on early childhood caries in its prevention and control. The number one thing that I think you can now do to get the most bang for the buck is to stem the tide of ongoing disease and turn off the tap instead of chasing after the repair of existing disease.

Thanks very much. [Applause]

ED HOWARD, EXECUTIVE VICE PRESIDENT, ALLIANCE FOR HEALTH REFORM: Thank you. There is by the way a very nice summation of some of the bills that Burt was referring to and the dental health provisions therein in your packets and that was put together by the CD.

We are going to hear next from William Prentice. The first logical place to look for solutions for problems in dentistry is to America's dentists and Mr. Prentice represents those dentists as Associate Executive Director for Governmental Affairs of the American Dental Association here in Washington. So we are very pleased to have you with us and it is an important voice that we need to hear in the debate over what to do about these problems. Bill?

WILLIAM PRENTICE, GOVERNMENT AFFAIRS, AMERICAN DENTAL ASSOCIATION: Thank you, Ed. I appreciate having this opportunity and I thank the Alliance for hosting this session. I think it is very important.

On behalf of the American Dental Association and I am in charge of governed affairs, so all the federal lobbying that we do we do here on Capital Hill or with the Federal Agencies. And it might surprise you to learn that I would say that safely 75 to 80-percent of the time we spend advocating, we spend advocating on behalf of access issues. About approving access to oral health care for the underserved and that is either

through working on it directly on some of the legislation that Dr. Goodman referenced and had up on his slides. Or whether it is some of the tangential issues like fluoridation or improving the public health infrastructure or tobacco control. They are all intra-related and I think they are all pieces of the puzzle. I want to compliment the Kaiser Commission for the excellent report that they just released today on oral health. I think that if you look at that it gives you a very good road map of all the different issues that are in play and all the different challenges we face as we try to improve access to oral health to the populations that have been mentioned by the previous speakers.

From our view-point the starting point and the ending point has to be funding. You know there are a number of different things that can be done but if we do not do something we cannot convince policy makers of the importance of improving access to oral health. If we cannot get them to see the importance by devoting funding to improve Medicaid and SCHIP then I think the remainder are not going to be good enough to do the job.

It was mentioned before I think that the number of dentists that can afford to participate in the Medicaid Program varies state by state. That is a by-product of the fact that the Program is set up as such that your state legislatures

determine the funding for its Medicaid Program. It determines how much of that meager pot of money is going to be allocated to dental care. Historically in state after state after state we have seen them not do a good enough job. Dr. Goodman talked about Maryland's recent commitment to increase funding in that state that is a by-product of that tragedy. Of course it is tragic that it takes a child dying to convince policy makers of the importance of oral health and the importance of that funding. Unfortunately that seems to be the case and it is shameful. We think that if we cannot convince policy makers to increase reimbursement than the rest of it is going to be for naught.

One of the things that I have been recently telling our members of Congress, of which we have many friends on both sides of the aisle, is they as politicians are very good at promising coverage and very bad at paying for care. What we need them to do is to recognize that it is not good enough to just pass legislation expanding coverage and expanding programs if you are not going to provide the financial commitment to ensure that those mandates and those coverages can be provided by health care professionals. That is our mantra as we go into the next Congress where I think health care reform will be at the forefront.

There is going to be a lot of talk about expanding access to care. I think our job is going to be is to be the ankle biter. To be the one reminding people that just promising coverage is one thing but we need that financial commitment.

One of the other topics that I have been asked to discuss actually was workforce and whether or not the dental workforce is sufficient to meet this unmet need. I do not know if we know the answer to that question because I think that these programs like Medicaid and SCHIP have been so drastically under funded that it is almost impossible in many states for dentists to participate in the programs and not lose money as they see each patient. It is not a matter of making money. It is a matter of how much money your going to lose in some instances when you see a Medicaid or SCHIP patient. I think that until we see whether of not we can get reimbursed at a level to get sufficient dentists to participate in the programs we do not know if there is a shortage in all honesty.

We know there is a mal-distribution. I think clearly there are parts to this country that there are just not enough people in a given community to support a private practice dentist or a private medical professional or supermarket and clearly we are going to need the government to step in and come

up with ways to try and get dental care into those areas where you cannot have a private practice in dentist or physician.

In many of the areas of the country, there are dentists. There is just no way of trying to get them into the program and get them to participate. And I think that if the numbers that Dr. Goodman showed, I think that Burt knows of this as well that if you can get reimbursement at a certain level you are going to get dentists to participate in the program. I think that is our challenge to try and convince policy makers to do that.

I should have started off by mentioning that I am joined here by a colleague, Dr. John Luther, who is our Senior Vice President for Dental Practice who works on a lot of access and related issues from the professional side. When it comes to Q & A he is going to join me up here and help answer questions as he is the thinker and I am just the talker.

Fundamentally, I think that when it comes to expansion of these programs the place that I think we see the biggest need, other than obviously as mentioned funding the current programs properly, is Medicaid eligible adults. As was referenced by Diane, in too many states there is no coverage for Medicaid eligible adults for dental care and we think that is shameful. When I have talked to, for example, Senator Ron Widen who has a very prominent bi-partisan health care reform

bill that he is looking to push in the next Congress and I talked to him about this and told him about this gap he himself was appalled to find out that the federal government does not require states to cover Medicaid eligible adults, those at the bottom end of the economic latter to get dental care. When you think about the economic impacts of that and the societal impacts of that and the psychological impacts of that for that population it is dramatic. I cannot think of anything else you could do beyond obviously the reimbursement that I keep harping on to get more kids care under Medicaid and SCHIP than to ensure that their parents have coverage. So that if we do nothing else I would love to see the next Congress tackle that issue and ensure that Medicaid eligible adults are covered under the Medicaid Program. I think that will not only help those adults but as I said I think you will see many more children enter the program and get care as well.

With that I think I will stop and I will let you get on to the next speaker, Ed.

ED HOWARD, EXECUTIVE VICE PRESIDENT, ALLIANCE FOR HEALTH REFORM: Thanks very much, Bill. Our next speaker, our final Panelist is Jack Bresch who is the Associate Executive Director of the American Dental Education Association, ADEA, which represents all the dental schools in the country. Jack has been lobbying us at the Alliance to hold a briefing on this

topic for years and could not have put it together this time without him. He also has Hill service in his background and a stint at ACTION the agency that houses Vista, the Peace Corp and other agencies. We are very pleased to finally have you on this panel that you have been having us hold for year. Jack?

JACK BRESCH, DIRECTOR, AMERICAN DENTAL EDUCATION ASSOCIATION: Thank you, Ed and thank you, Diane for holding this and I do believe today's session is simply another demonstration that to profile oral health and its value and its importance is being elevated on Capital Hill by policy makers. Thank you both for this attention.

I would like just briefly to talk about three subjects. The first is talk about academic dental institutions, dental schools as safety net providers. The second, I want to briefly describe one of the proposed workforce models and thirdly, I wanted tell you ADEA's the American Dental Education Association's position on health care reform.

ADEA represents, as Ed mentioned, all the 57 dental schools in the United States but also 714 dental residency training programs, 577 allied dental programs, more than 12,000 faculty who educate and train nearly 50,000 dental students in these institutions. Our members are in 45 states including the District of Columbia and Puerto Rico and 44 of the 57 U.S. dental schools are part in fact of academic health centers.

ADEA's members are dedicated to the advancement of research, the education of oral health professionals and thirdly and importantly the delivery of oral health care to improve the oral health of the public. As providers of care dental schools serve two purposes, one, they are the safety net providers for the uninsured and the underinsured. They are also dental homes to a broad array of vulnerable and underserved low-income patient populations.

Second of all, they are centers for one-stop, comprehensive oral health care services including a range of specialty services. Many, many people in this country depend upon dental school clinics for their oral health care. And the reason is unfortunately simple. There are approximately 134 million adults and children who lack dental insurance in the United States. Americans spend roughly 91 and a half billion dollars on dental procedures in the year 2006, 86 billion dollars of which was paid either through out-of-pocket or through private insurance. Only five and a half billion, less than six percent was paid through public programs such as Medicare, Medicaid and SCHIP.

There are currently 3,700 what we call dental health professional shortage areas. HIPSAs, dental HIPSAs, these are geographic areas in the country without enough dental professionals to serve the population. HHS makes those

determinations. Over the past 15 years dental HIPSAs have grown and this shows the emergence of the need, have grown from 792 to 3,527. During that same time the number of dentists necessary to provide services in these areas the need has grown from 1,400 dentists to 9,164.

Medicaid, as you know, is the major source of oral health care for vulnerable and low-income populations. All 25 million children in Medicaid are eligible for the only guaranteed benefit in any public program and that is the Early Periodic Screening and Diagnosis and Treatment Program EPSDT. But as you know or as you should know, enrollment in Medicaid does not ensure receipt of oral health services. In 2005 the total combined state and federal spending on Medicaid dental services was 3.4 billion. That is 1.3-percent of all Medicaid funding. Unrealistically low as Bill as mentioned. Unrealistically low reimbursement rates and cumbersome administrative requirements discourage many private practicing dentists from accepting Medicaid patients.

Dental schools face a significant challenge. There is a significant faculty shortage. There are at least 400 dental school faculty vacancies 75-percent of which are full time positions. Despite our ongoing efforts the diversity of our student population is low. Only five percent African American, six percent Hispanic, less than one percent Native American and

23-percent Asian. I said in spite of our efforts and have made a number of efforts. We have partnered with and have been funded through a number of foundations, for instance, the Robert Wood Johnson Foundation, The California Endowment, The W.K. Kellogg Foundation and The Josia Macy, Jr. Foundation in order to address the diversity issues in dental education.

The second issue I want to talk about briefly is one that is more fully addressed in your packet. There is an article from the Journal of Dental Education, which outlines three different workforce models that are presently being discussed in the country. The one I want to talk about is called Advanced Dental Hygiene Practitioner, it has been proposed by the American Dental Hygienist Association. ADA has a model and there is one in Alaska. Let me say before I do that though, that our policy, the Association policy supports extended employment of Allied dental professionals, hygienists and lab technicians as one way to improve oral health care delivery and availability.

It is not our role however to develop new workforce models. Our role and our challenge, is to anticipate and prepare the changes in the educational preparation of Allied dental professionals.

The ADHP, the Advance Dental Hygiene Practitioners, is a mid-level oral health care provider that will leverage the

existing dental hygiene workforce to have an even greater impact on the delivery of care for those in need. He or she will be educated and licensed to provide both preventive and limited restorative services to meet identified patient needs. He or she will be a licensed dental hygienist, educated at the Master's level, will administer minimally invasive restorative services and will have authority to write prescriptions. And finally will provide care in a variety of public health settings like schools and clinic and long-term care facilities.

The concept of a mid-level provider in oral health is not new. Currently more than 40 countries including Canada, New Zealand, Australia and the United Kingdom allow mid-level practitioners to practice oral health. I urge you to take a look at the JDE article to get a more comprehensive view of the three proposals that are out there.

Let me conclude by sharing with you ADEA's point of view with regard to health care reform. Our board of directors has adopted six core value principles and has enunciated a policy statement, which we bring to the table in the upcoming national debate on health care reform. I will just identify the six principles.

The first is that the availability of oral health care fulfills a fundamental human need and is necessary for the attainment of general health. Second, the needs of vulnerable

populations have a unique priority. Thirdly, prevention is the foundation for ensuring general and oral health and for controlling costs within the U.S. health care system.

Fourth, the financial burden of insuring coverage for health care, including oral health care, should be equitably shared by all stakeholders. Fifth, a diverse and culturally competent workforce is necessary, is essential to meet the general and oral health needs of our demographically changing system and finally, our nation's domestic productivity and global competitiveness are negatively impacted by the huge and growing number of Americans without health care including oral health care.

We believe good oral health is essential for general health. We believe that every American should receive the care necessary for good oral health. And so our message at this early stage in the debate is that any comprehensive reform of the U.S. health care system must include coverage and access to affordable oral health services. As the voice of dental education ADEA believes that dental educators and researchers have a professional obligation to promote access to oral health care.

Thank you. [Applause]

ED HOWARD, EXECUTIVE VICE PRESIDENT, ALLIANCE FOR HEALTH REFORM: Thank you, Jack. And as Bill Prentice said, we

will be joined for the Q & A period by John Luther who is the Senior Vice President of ADA's Division of Dental Practice and Dental Affairs. He is a dentist himself and has worked on many of the issues being discussed today. As I mentioned you have the opportunity to write a question on the green card. Hold it up and someone will bring it forward and there are microphones on both sides and in the middle that you can use to ask questions orally, and that would be healthy. That is right, use your mouth as Diane said.

Jack, just a factual clarification, your association includes the other dental professionals?

JACK BRESCH, DIRECTOR, AMERICAN DENTAL EDUCATION ASSOCIATION: Allied Dental Health Professionals. Dental hygienists, dental assistants and dental laboratory technicians.

ED HOWARD, EXECUTIVE VICE PRESIDENT, ALLIANCE FOR HEALTH REFORM: And do you folks have positions on some of the scope of practice questions that were raised earlier? And if you have 50,000 students in your system how well does that measure up the 100s of dentists we are short in the shortage areas? What are the issues involved in trying to fit the right people into the right places?

JACK BRESCH, DIRECTOR, AMERICAN DENTAL EDUCATION ASSOCIATION: Ed, our focus is on accreditations programs on

the certification of some of these Allied Dental Health Professions and the licensure of dental hygienists. That is our focus. We are safety net providers. We are also educators and therefore whatever workforce models are being discussed are fine. Our job is to teach whatever has been accepted.

ED HOWARD, EXECUTIVE VICE PRESIDENT, ALLIANCE FOR HEALTH REFORM: Bill or John do you want to talk about that?

WILLIAM PRENTICE, GOVERNMENT AFFAIRS, AMERICAN DENTAL ASSOCIATION: As I mentioned, Ed, I think one of things we do not know is that if you properly fund these programs you will have an army of more dentists participating around the country I think taking a large chunk of the problem. If you are still going to have a distribution problem because there simply are areas of the country in communities that cannot support a health profession and that is where of course you have federally qualified health centers, you have community health centers, you have ways to try to extend medical and dental care into those areas that will also pick up a big piece of this problem.

ED HOWARD, EXECUTIVE VICE PRESIDENT, ALLIANCE FOR HEALTH REFORM: Yes, would you identify yourself?

LIZ SAVAGE: Hi, I am Liz Savage [misspelled?] and I work for ARK which is a national organization representing people with intellectual disabilities, formerly referred to as

mental retardation as well as I represent United Cerebral Palsy. On the issues you underscore on lack of adequate reimbursement, et cetera are key issues for us. But on the individuals we represent both children and adults have an additional barrier to dental care and that is often due to the significance of their disability they have difficulty in communicating with dental professionals. They often need anesthesia, for example and they are often more harder to treat and have harder access issues.

I have two questions. One is, with respect to the workforce shortage, I have heard that there has been legislation introduced to provide loan forgiveness for dental students. I do not know if anyone is familiar with that? Like there is for other forms of tuition forgiveness to encourage more people to go into the profession.

JACK BRESCH, DIRECTOR, AMERICAN DENTAL EDUCATION ASSOCIATION: The average dental student comes out of dental school with about $172,00 debt. We have been advocating for some time for an increase in the provisions that would either forgive or at least grant some relief for these loan programs. Some of them have been included in the Higher Education Act. We are continuing to work on more of them but there are certainly loan programs for dental student and Allied dental students.

WILLIAM PRENTICE, GOVERNMENT AFFAIRS, AMERICAN DENTAL ASSOCIATION: And to speak to the population that you are talking about there is a Special Care Dentistry Association which are dentists who specialize in trying to treat the developmentally disabled, people with special needs and the frail elderly. We are working with them and hope to have a piece of legislation that we can get introduced in the next Congress to try and address the fact that there are not enough dentists that are trained to treat those populations. As well as to try to get increased Medicaid match to help out, to ensure that there is a funding stream to get those people the dental care that they need.

LIZ SAVAGE: Well there are many of us in the disability community who would love to work with you on that.

HARRY GOODMAN, DIRECTOR OF ORAL HEALTH, STATE OF MARYLAND: I would just like to add that in Maryland we have something called the Maryland Loan Assistance Repayment Program. I think it is a leader in the country because it does not require a dentist to be in a health profession shortage area. Essentially we look at the whole state as being a shortage area and we need more funding but they receive about $100,000 for a three-year commitment to treating Medicaid children, a certain proportion of the population base. I really think that should be a model for the country as well.

It has really worked well in Maryland. We just need to up it because as Jack said it is $172,000 loan indebtedness and I think that is one of the reasons why cannot get as many dental students as we want to go out into the community and treat these special populations because they have to hit the road running making income because they are already behind the eight ball just from their dental debts.

JOHN LUTHER: Jack is way low on tuition for dental students today. The majority of these schools now are some $70,000 and $80,000 a year times four years.

NATALIA SANCHEZ: Good afternoon. My name is Natalia Sanchez [misspelled?] and I am a fellow health policy fellow in the office of Senator Snow but actually next month I will be starting dental school at the University of Connecticut. So my question is actually directed at Mr. Prentice and Mr. Luther.

I always wondered why the American Dental Association did not mandate or require from graduating dental students a year of rural rotation. I understand that this is a program which many other countries have and provide graduating dentists go off for a year and serve in an under served clinic or in an area of a safety net dental clinic. So I always that that would be a fantastic way to offer services and that just be a part of their education.

WILLIAM PRENTICE, GOVERNMENT AFFAIRS, AMERICAN DENTAL ASSOCIATION: Actually that is a debate that is going on in within The American Dental Association right now. The concept of a fifth year of service both for the fact of getting additional training and developing additional skills as a new practitioner, as well as obviously creating a small army new dentists who might be able to work in community health centers and rural health centers and help to provide care. That is something that we are actually actively considering. There clearly are not enough residency programs in this country right now, dental residency programs. There is obviously a battle competing trying to get into those residency programs and would love to see if we could do something about that.

John, anything that you would like to add on that?

JOHN LUTHER: We are looking at it right now but again, even do something like this we have to have slots for those students in their fifth year and they also have to be paid adequately.

NATALIA SANCHEZ: Okay. Wonderful, thank you.

JACK BRESCH, DIRECTOR, AMERICAN DENTAL EDUCATION ASSOCIATION: I might add that we graduate on average 4,500 dental students a year. There are currently only about 2,500 residency slots in the country. They are very competitive. We have as many as 28 or 3,000 applicants for those 2,500 slots.

So there is a challenge. ADEA encourages every dental student to pursue graduate education but we are faced with the reality there simply are not enough slots to accommodate as many dental students graduates as would like to attend a residency training program.

BURTON EDELSTEIN, CHAIRMAN, CHILDREN'S DENTAL HEALTH PROJECT: And I would like to follow-up on Jack's comment about the need for post-doctoral training in dentistry. I teach at Columbia University in the City of New York and New York State recently mandated that all dental students must complete a year of post-doctoral training. That has led to an increase development of post-doctoral training opportunities. So it is a bit of a push-me, pull-me relationship. The mandate does lead to more interest to developing this.

With regard to care of people with special needs these advanced training in general dentistry programs as well as specialty programs do far better prepare to be able to care for special needs populations as well as to serve more under-served people. Thank you.

ROBERTA DOWNING: Hi, my name is Roberta Downing [misspelled?] and I work for Senator Sherrod Brown. Senator Brown was actually here and had to leave after the last speaker for his next appointment but I have not heard anybody mention Senator Brown's Bill so I thought I would make a plug for it if

there are any hill staffers in the room because we would really love to have more co-sponsors and it really speaks to a lot of the issues that have been raised today. It is S2723, it is actually named after Deamonte Driver. It is the Deamonte Driver Dental Care Access Improvement Act and it was introduced by Senators Brown and Cochran and actually we worked on a bicameral basis which was kind of unusual with Congressman Cummings office introduced the Bill.

The Bill has been endorsed by the ADA and the Children's Health Project. And it has grants so that Community LN ADEA [misspelled?] as well, sorry, and it has grants to community health centers to expand their dental services that they can provide. It has grants for pediatric training. There is a tax credit for dentists who serve uninsured, SCHIP and Medicaid patients to provide an extra incentive given the problems we do have with reimbursement. It also has a grant to test out a mid-level provider and has some provisions around dental quality. So, we would love to have MARCO [misspelled?] in the future for the presenters. We would love to have it advertised more widely. Thank you.

WILLIAM PRENTICE, GOVERNMENT AFFAIRS, AMERICAN DENTAL ASSOCIATION: Roberta, thank you. Sherrod has always been a very strong proponent of improving access to oral health. He has been a great friend of ours for many years. There are a

number of legislators on both sides of aisle that have been really good friends and that have really stood up to try and improve access to our health with Sherrod being one of the top ones. I wish I had noticed that he was there or I would have called on him myself.

WHITNEY WYCOFF: Hi, my name is Whitney Wycoff [misspelled?] and I am with *Congressional Quarterly*. I have a question about the dental health under-provided service areas that you were talking about earlier. I know that in rural areas some children who have trouble accessing general dentists have even more trouble accessing specialists. For example in Illinois in some rural counties children's families would drive up to 100 miles to find a specialist that can address the specific needs of their children. I want to know if these areas that have been calculated take into consideration a lack of access for people who are on government provided insurance and if it also considers specialties, so that is my question.

BURTON EDELSTEIN, CHAIRMAN, CHILDREN'S DENTAL HEALTH PROJECT: Well, I would be happy to address the specialty issue. It does not consider specialty care and if you just take a look at the numbers you see what the issue is for specialty care. Children with the greatest needs are the kids with the least access to care but there are only about 4,000 maybe tops 5,000 practicing pediatric dentistry specialists in

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the country. Now, we do make a real effort through dental education that general dentists can provide substantial amount of care. But those kids that have really significant problems particularly if they are very young or if they have special needs or if they have very severe disease, find themselves in need of the specialist, the number of the specialists or the number of pediatricians. It gives you sort of a frame of reference to appreciate how severe the inadequacy of pediatric dentists is.

JACK BRESCH, DIRECTOR, AMERICAN DENTAL EDUCATION ASSOCIATION: The situation you describe also sometimes is handled by the dental school clinic or satellite clinic that is operated by the dental school. Third and fourth year students plus residence people who have graduated and are now doing a residency training program are available frequently in those general school clinics. So, for instance, I think you mentioned Illinois. In down state Illinois, Southern Illinois University has a dental school. I am sure it has at least three satellite clinics, certainly the school has a clinic. This is a part of the mission of dental schools being safety net providers. There is an opportunity in that situation in many cases to have access to a resident and specialist where other areas might not provide that opportunity.

JOHN LUTHER: This is an area where innovative approaches to solving these problems can be looked at such as the use of telemedicine and tele-dentistry and then also perhaps having a mid-level provider that can triage care so that a dental or medical provider can come in on a part-time basis and see those with need.

WHITNEY WYCOFF: Dr. Luther, could you expand on what telemedicine and tele dentistry would mean in a dental practice?

JOHN LUTHER: It would be the use of telecommunication where a dentist or a specialist in a remote site to be able to clearly assess a situation and then when he or she comes in to actually treat the patients have everything set up and be ready to go. And again, it increases productivity for someone having to travel a great distance.

WHITNEY WYCOFF: Okay. Thank you.

TATE HEUER: I am Tate Heuer [misspelled?] with Senator Prior's office and considering working families that that do not qualify for Medicaid today and how they could potentially be impacted through health reform. I know there has been a lot of discussion of modeling, health reform proposals for the uninsured or the small businesses to reflect the Federal Employees Health Benefits Program which really does not have much in terms of standard dental care but I do believe it is in

the second year of a program that has supplemental non-subsidized dental care. People talk about modeling health reform after the health care that members of Congress have. Well, that is the health program that federal employees have or also people that would work, you know, doing laundry at an Air Force Base or part-time postal employees.

Can you talk a little bit about how the Federal Employees Health Benefits Programs work and how good of a model that would be and try to get coverage to working families today that are uninsured and hopefully will get coverage through the new federal efforts.

ED HOWARD, EXECUTIVE VICE PRESIDENT, ALLIANCE FOR HEALTH REFORM: Anybody? Burt?

BURTON EDELSTEIN, CHAIRMAN, CHILDREN'S DENTAL HEALTH PROJECT: It does not. [Laughter] It does not work. Citing the Federal Employee Health Benefit Plan or State Employee Health Benefit Plans or the largest managed care organization in the state are good examples of how the disconnect, the historical disconnect between dental coverage and medical coverage is manifest. These do make sense when policy makers are seeking to emulate the commercial environment but because the commercial environment has that historical accident of excluding dental and making dental a separate system we end up with model really has no direct application. I am speaking

specifically about children. I recently completed an analysis of the State Employee Health Benefit Plan and found that very few states mandate or provide, I should say, a dental benefit for dependents. A few more states make it a buy-in option and many states had not even the availability of such an option.

ED HOWARD, EXECUTIVE VICE PRESIDENT, ALLIANCE FOR HEALTH REFORM: Diane?

DIANE ROWLAND, KAISER COMMISSION ON MEDICAID AND THE UNINSURED: I think it is important to note as I said in my earlier comments that over half of the employers that offer health benefits to their workers do not include dental benefits as a part of that and even when they do offer dental benefits they are sometimes very limited contributions to a limited plan. So to answer your question about modeling most of the modeling efforts that go on around health care reform are based on either the employer packages or slimmer packages even than the employer package and dental benefits I can assure you are rarely included in the cost of coverage that the modeling efforts are coming up with.

WILLIAM PRENTICE, GOVERNMENT AFFAIRS, AMERICAN DENTAL ASSOCIATION: And if I could just follow up on that because it really is almost a misnomer to refer to as insurance because as Diane mentioned in almost all instances it is actually a pre-

paid dental benefit with a very limited amount of funding or coverage for a given year.

JACK BRESCH, DIRECTOR, AMERICAN DENTAL EDUCATION ASSOCIATION: The previous speakers have mentioned this is a good example of the reality of oral health vis-a-vie general health. There is a separation not only of the financing and delivery system for oral health but also the education. There is also an attitude that describes a lower priority to oral health than to general health or to medical health. So, that is the challenge that is the part of the debate we are focused on in the larger context of health care reform. How do we get people to value and appreciate the importance or oral health and to see it as adjunct to general health.

DIANE ROWLAND, KAISER COMMISSION ON MEDICAID AND THE UNINSURED: We actually have a question that says that if dental health is so critical to overall care why are separating these and seeking to raise dental care to parody with medical care instead of really intergrading the two? And I think that is what you have all been speaking to and answering this one question. We will go back to the mic.

NICHOLAS GORDON: Good afternoon. My name is Nicholas Gordon [misspelled?]. This summer I have worked in Congressman Jim Clyburn's office as a Barbara Jordan Health Policy Scholar and I will also be attending dental school in about a month.

My question is Mr. Bresch, you have talked a little bit about efforts to increase diversity in dental schools and the fact that despite efforts dental schools still not as diverse as we would like them to be. And as a product of some efforts to increase diversity I feel that they were very effective for me. My question is what I guess have we learned from all this? What does work? What does not work? I am not sure if you could speak a little bit on that so that we can move forward and make sure that dental schools are reflective of the general population?

JACK BRESCH, DIRECTOR, AMERICAN DENTAL EDUCATION ASSOCIATION: We are in collaboration currently over a three year period with the Association of American Medical Colleges AAMC. Whereby we take 19,00 students, 333 dental, 15,064 medical, these are college freshman and sophomores. We take them away to 10 different sites, usually with medical schools and dental schools and basically give them basic science courses so that they are better prepared to take the admissions tests for dental schools or for medical schools.

We have got to get young people early in the process, as early as grade school. We have go to show them the importance and the significance of this health profession. It is too late. They do not have the scientific background. They do not have some of the educational tools that are necessary.

So this program that we are collaborating with AAMC is an effort to bring under-represented students up to speed so that in fact we can have a larger proportion of minority students in our dental schools.

The numbers are not impressive and we do not pretend that they are. Without being defensive we wonder without our efforts if the numbers would not even be lower. But we have a huge challenge because we are talking about an increasingly demographically different society. We are talking about the reality that minority health care professionals tend to go back to their communities to treat their populations and we simply do not have enough minority health care professionals.

HARRY GOODMAN, DIRECTOR OF ORAL HEALTH, STATE OF MARYLAND: I would just like to add that we absolutely need minority representation in our schools and our professions. But we also make sure that we create a system that they are able to, once they graduate, to truly be able to treat the population that they need to treat or we are going to have the issues basically, regardless, because again with loan indebtedness what-have-you there are just tremendous barriers. And with low reimbursement through Medicaid programs, through restricted coverage, you are going to have the same barriers as any other practitioner. The system really needs to work for everybody and obviously we have to get that representation in

but it is not going to be effective unless we fix the Medicaid Program and similar programs so that we are truly able to treat the population you really need to treat.

SUSAN POLYDORF: Good afternoon. Susan Polydorf [misspelled?] and I am a public health dental hygienist from Montgomery County Health and Human Services. I would like to ask Mr. Prentice, in light of Mr. Bresch's talk about the three levels of mid-level providers that he mentioned. Minnesota just passed and the governor has signed it in the spring, the licensure of the ADHP, the Advanced Dental Hygiene Practitioner. And I know that that legislation was proposed by Anne Lynch, District 19 Legislator and supported by the safety net providers. I would like to know if the American Dental Association has supported that and what they will be doing to make sure that program does go and is a success in the State of Minnesota?

WILLIAM PRENTICE, GOVERNMENT AFFAIRS, AMERICAN DENTAL ASSOCIATION: My understanding is that with the State of Minnesota passed was a requirement to establish an oral health practitioner model and that the exact specifics of what the scope of that provider have not been set yet and that the legislation created a study commission to help lay that out. I know that there are representatives from organized dentistry from the Minnesota Dental Association as part of that study

group. At this point I do not think we know what the outcome of that is though.

ED HOWARD, EXECUTIVE VICE PRESIDENT, ALLIANCE FOR HEALTH REFORM: Yes, go ahead.

LYN HAINGE: Hi, I am Lyn Hainge [misspelled?], the Executive Director of the Campbell Hoffman Foundation. We are located in Northern Virginia and one of our main focus areas is on oral health. I have one comment and one question.

My comment comes from a convening of oral health safety net providers that was done recently in my region and among them was a representative from one of the nine hospitals in Northern Virginia who told us that last year there were over 480 individuals who came to the emergency department of that hospital for oral health reasons. That is potentially multiplied by nine because there were nine hospitals in our region although we do not have the stats for that yet.

So if you have any comments about the increase in oral health urgency among adults in emergency rooms I would appreciate that.

The other thing that I have for you was a question. I understand that health profession shortage definition calculations are in the process of being reviewed and potentially changed. And I would like to know the rules of the

game are likely to change as applies to health profession shortage areas.

JOHN LUTHER: There is no question that treatment in an emergency room significantly drives costs of oral health care and I think all of us would agree that we would want to drive treatment to early intervention, prevention and then also behavioral changes.

HARRY GOODMAN, DIRECTOR OF ORAL HEALTH, STATE OF MARYLAND: Regarding the emergency room issue, in Maryland an emergency room visit costs approximately 300 dollars per visit. And as you well know what the patient basically receives is not definitive treatment but just basically a prescription and an assessment and then they can often be back within a certain period of time to once again charge the state an additional cost again. In my earlier slide this all could be averted if we had early intervention at a far lower cost in terms of preventative services.

We also have OR cases where children are seen, again as Burton said, earlier by the time a child is two or three it is too late. And children are placed into an operating room facility to get the care done at a cost to the state of anywhere between 3,000 to 5,000 dollars a case. Again, compared to providing some basic preventive services at a far, far lower cost. It really is an amazing situation.

BURTON EDELSTEIN, CHAIRMAN, CHILDREN'S DENTAL HEALTH

PROJECT: And I would like to note that although children have far better coverage because of Medicaid and SCHIP, although those programs so profoundly and so often fail them, they often end up in the emergency room as well. Now your question was about adults, but the kids often end up in the emergency room as well. Where again palliative care just buys them a little time until the next toothache.

But Harry also mentioned the operating room and the extreme costs that are involved in that treatment. One of the things that really drives home the importance of understanding the disease process in dealing with the disease process such that we cut off the tide of new disease is that 40-percent of children who have extensive and expensive dental rehabilitation in the operating room have new cavities within two years. I do not know of any other surgical procedure that we would subject preschool children to with a couple hours of general anesthesia that has that kind of failure rate. We really need to get down to the fundamental issues of disease management and apply those principles from pediatrics to the dental care of children.

WILLIAM PRENTICE, GOVERNMENT AFFAIRS, AMERICAN DENTAL ASSOCIATION: And to build on what Burt and Harry were saying, you can pay me now or you can me later and if we devote

sufficient resources to these programs now and get that early intervention and get them on the road to children starting out with good oral health and infusing them with the idea of prevention and of doing just basic oral hygiene, we are going to end up with a population of adults that are not going to have nearly severe oral health problems that we currently face. If we can just devote a small amount of money now to fix this problem we are going to save a lot of money on the back end.

DIANE ROWLAND, KAISER COMMISSION ON MEDICAID AND THE UNINSURED: We actually have a number of questions that came from you, the audience related to early intervention even in a more broad based way.

First we have questions about the relationship between the infant feeding method, bottle formula and children's oral health and then we have a question about maternal pre-natal oral health and its impact on the children and what can be done about it. And finally, by the time children get to school what does the nutrition programs have to do with oral health, what more can be done to bring in fluoride health focused activities in the school situation. How can we intervene more broadly.

WILLIAM PRENTICE, GOVERNMENT AFFAIRS, AMERICAN DENTAL ASSOCIATION: As a lay-person on a lot of these issues, one of the things that you might find surprising is that we spend so much of our time just fighting for fluoridation and trying to

just maintain the fluoridation in the places that it exists because you know there is such distrust for science in this country. So many different places to get their information that we actually get attacked for trying to fluoridate water and supporting fluoridation in various communities which is probably the cheapest and most effective way to try and stem this disease. If we could just get that off the front burner and not have to spend so much time just trying to defend fluoridation then we would have so much more time to be able to focus on a lot of these other problems.

BURTON EDELSTEIN, CHAIRMAN, CHILDREN'S DENTAL HEALTH PROJECT: So, Diane asked me to address moms. And the issue there is that that dental caries tooth decay which used to be called early childhood tooth decay, used to be called baby bottle tooth decay to reflect the high frequency exposure of sugar from the bottle that keeps this disease process active. It is now more appropriately called early child tooth decay or early childhood caries to represent the population that is affected because it is not as tightly related to the bottle. There are other feeding mechanisms, sippy cups and other frequent ingestion of sugar laden foods that keep the process going.

But with regard to the moms, dental caries is an infectious transmissible disease. The bacteria that initiate

the disease are typically acquired by children from their mothers. So we can pick out, even prenatally those potential children, those future children who will be at the highest risk of experiencing early tooth decay based upon their mother's dental experience. And so there are interventions, science based interventions, that could be applied. But this calls into question the application of concepts of primary prevention, risk assessment, disease management, disease suppression. We are in a policy forum today so let me show you how we can quickly relate those both to practice and to policy.

The clinicians have responded to this knowledge by expanding their concern for early childhood intervention. The American Dental Association, The American Academy of Pediatric Dentistry, The American Academy of Pediatrics and others now endorse beginning dental care at age one and the notion of the dental home and infant oral health care. That is a clinical policy.

On a more public policy basis there are a number of opportunities to apply this scientific knowledge to changes in public policy. First off, NIH could do much more work than it has in recent years whether through the Institute of Child Health and Human Development or whether through the National Institute for Dental and Craniofacial Research on dental caries management and prevention.

Secondly, over at CMS there could be more of a focus on using incentives to attend to early childhood oral health care and the use of transformation grants as have been used in other programs to institute local and retinal efforts to develop systems for early intervention. Over at CDC if there were as much attention to early childhood tooth decay prevention as there is to fluoridation much could be done. At the USDA the Food and Nutrition Service, the WIC Program could have a potentially powerful role in dealing with the dietary aspect of this early onset disease.

There are a number of federal programs that require authorization and appropriations from this Congress that could have their attention turned to primary prevention and disease suppression.

DIANE ROWLAND, KAISER COMMISSION ON MEDICAID AND THE UNINSURED:: I think in regard to the prenatal care issue, it is also one that we talked about the gap of coverage for adults under Medicaid. We obviously cover pregnant women at a very higher income level to try and ensure healthy infants are born to those mothers but do not include dental benefits as part of the package they are included for.

BURTON EDELSTEIN, CHAIRMAN, CHILDREN'S DENTAL HEALTH PROJECT: I would be remiss if I failed to mention the growing evidence of relationship between prenatal oral health care and

successful full term deliveries. That is one of the many examples of the oral systemic connection and the impact of improving oral health on other health outcomes.

HARRY GOODMAN, DIRECTOR OF ORAL HEALTH, STATE OF MARYLAND: I would just like to add also before this if forgotten the perfect venue for a lot of this is the schools where a lot of this can be applied. And I think school based health centers provide an additional venue to provide oral health care and schools themselves can be used to provide services and certainly link services into dental treatment.

I think the model for that is the Head Start Programs and the Head Start basically targets all the populations that Burt was just discussing. Actually early Head Start, most people do not know, actually begins with pregnant women and targets children up to the age of three. And then Head Start takes over from there from three to five years old and Head Start is a perfect venue. And what Head Start does is they have daily tooth brushing exercises using fluorides all the time and Head Start of course has performance standards to address dental. The school as the venue so we do not have that issue of how to maybe get the students to the dentist or the hygienist. We have the target population right there where we can provide a number of services and then through certain

creative mechanisms link them into definitive treatment or restorative care if needed.

WILLIAM PRENTICE, GOVERNMENT AFFAIRS, AMERICAN DENTAL ASSOCIATION: There is also food choices available to kids in schools that we have supported to try and give the children healthier choices in the schools that they do not have quite as often an opportunity to reach for a sugary snack. That they can reach for something that would not have as bad impact on their oral health.

ED HOWARD, EXECUTIVE VICE PRESIDENT, ALLIANCE FOR HEALTH REFORM: We have just about 10 minutes left and we have a couple of people standing with microphones. I know that we are not going to get to all of the cards. Let me also take this opportunity to ask you to pull out your evaluation forms and start filling them out as you listen exchanges. And Bob you have been very patient.

BOB GRIS: I am Bob Gris [misspelled?] with the Institute of Social Medicine and Community Health. I am very excited by the last exchange because it seems like the approach to dental care involves more than just reimbursing physicians. It has to do with the way the whole community functions and the interventions of the school and the water supply and all of these things. I am wondering if the model for universal health care does not lie in the example of more effective and cost

effective dental care. It seems like the whole panel has been talking about how parallel general health care is to dental care and we have not really made a good argument about the cost savings for universal health care at least politically even if the public favors it.

So I am wondering if the examples that you are advocating here would not lend itself to demonstrating the advantages of universal dental care first and the kinds of interventions that you have just been talking about. Would there not be cost savings to society if those things happened and would not the mechanisms already exist at the community level for implementing that?

WILLIAM PRENTICE, GOVERNMENT AFFAIRS, AMERICAN DENTAL ASSOCIATION: I do not know if I can answer that in depth and in detail but one thing I would offer is that dental care when it works properly is completely prevention based. Obviously if we could do that on the medical side the way it is done on the dental side when it is done successfully I think that that might be a recipe for improving oral and medical and overall health in America.

JACK BRESCH, DIRECTOR, AMERICAN DENTAL EDUCATION ASSOCIATION: I would remind you that the core value with regard to our health care reform position is that prevention is the foundation not only for ensuring general and oral health

but also for controlling cost. So certainly a dollar spent on prevention is many dollars saved on treatment down the line.

ED HOWARD, EXECUTIVE VICE PRESIDENT, ALLIANCE FOR HEALTH REFORM: We will have Peter Orzag [misspelled?] on this panel the next time we have it. [Laughter]

KAREN SEALANDER: Karen Sealander [misspelled?] with McDermott Will and Emory for the American Dental Hygienist Association. And I have a comment and a question and a point of clarification. First, thanks so much to Kaiser and the Alliance for hosting this briefing and drawing attention to the importance oral health to overall health and general well-being.

As the panelists said, dental disease is an infectious, transmissible disease that we can really fully prevent. So it makes it even more tragic that we have so many suffering from preventable dental disease. Given the fact there is an oral health access crisis. And that many workforce experts have that there is a dentist shortage and rapidly number of hygienists ADHA has called for an advanced dental hygiene practitioner and we appreciate Jack's description of it. It is a licensed dental hygienist who would go back and get a Masters Degree in Clinical Dental Hygiene, adding to the current preventive scope of practice of hygienists limited restorative and prescriptive authority. And there are some other proposals

for new models and the CHIPRA Bill called for a study of some of these.

And I was wondering if Bill could comment on the ADA's view with respect to new workforce models. And whether or not new providers should be licensed and graduated from an accredited institutions. And whether they think Congress might want to spend some money studying some of these new models.

Then just real quickly, that Minnesota Law, Bill is right it does direct a work group to come up with a new oral health practitioner and the scope of practice that work group is supposed to incorporate is very similar to the Advanced Dental Hygienist Practitioner.

WILLIAM PRENTICE, GOVERNMENT AFFAIRS, AMERICAN DENTAL ASSOCIATION: The ADA over the past few years has two work groups that came together to look at this issue. Whether we need an additional member of the dental team. We took testimony for a variety of different sources including the hygiene community. The position that we derived and that we came up with is called the Community Dental Health Coordinator. The idea is to basically merge the a social worker with some dental educations and some dental training to help be an extender in under served areas and into communities where there are not enough dentists. To try and get out into that community and make sure that people know of the importance of

oral health through increased oral health literacy and help kind of triage and get those patients to dentists so that they need. This is the best approach that we think is our best guess about what is needed to try and do this. There are obviously are other proposals, Karen mentioned one. Ours is not fully vetted. We are actually in the process now of doing demonstration projects in three different areas of the country and three different settings, to determine its viability and to determine whether it is going to work.

I do not know that you can tell from just drawing something on a piece of paper and deciding that this sounds good, whether it is actually going to be effective. I think the story has not been written yet in terms in determining what new member of the dental is going to work best. I think these things are blooming around the country at the state level. We have heard there is an effort a foot in Minnesota. There are other proposals going on. We are testing ours. I think that it is going to take some time to figure which new member of the dental team is going to work best.

JACK BRESCH, DIRECTOR, AMERICAN DENTAL EDUCATION ASSOCIATION:: I might point out 500 students graduate annually from dental schools, 23,000 Allied Health Professionals graduate annually. So the potential workforce is significant and as Bill said, it is a matter of figuring out exactly what

the scope of practice is with regard to their activities. But there is no doubt in our mind that there new functions and new responsibilities that Allied Dental Health Professionals are going to assume.

WILLIAM PRENTICE, GOVERNMENT AFFAIRS, AMERICAN DENTAL ASSOCIATION: The one concern I have with this workforce to date and scope or practice we all know is a very, very contentious issue whether it is in the dental field or in the medical field it occupies a lot of the political air in State Legislatures. There is always turf battles going on. One of the things that concerns me most about it and which I hope we do not continue to do is it gives legislators the opportunity to try and latch on workforce and a creation of a new model or a new program. There quick and easy solution to the access to oral care probably diverting time and attention what we all know and what I have said a hundred times already in the last two hours which you have got to do the hard work of increasing reimbursement and devoting more funding to these programs to building up the public health infrastructure. What I do not want to see us do is to give legislatures that easy answer, all I have to do is flip this switch, create this new provider and all the problems go away. Because it is not going to happen.

TIM ANDERSON: My name is Tim Anderson and I am actually a current dental student at the University of

Minnesota, so I am fairly familiar with this topic. My question goes out the Mr. Bresch and Parish [misspelled?]. You had mentioned that you ADEAs responsibility is for sitting the curriculum for Allied Dental Professionals.

My question is with this new advanced hygiene practitioner the scope of practice is vastly increased. The concern of dental students currently having is who is going to be teaching that because we are no longer talking about preventative care in the sense of seeing fluoridation and sealants. We are talking about surgeries and the removable permanent irreversible removal of tissue and my concern is that you mentioned there is such a shortage of dental faculty. Who do you see as the person or persons who are going to be responsible for educating these new practitioners if it is not the dentists or dental faculty training them who is going to be responsible for teaching surgery?

JACK BRESCH, DIRECTOR, AMERICAN DENTAL EDUCATION ASSOCIATION: You have identified the challenge and there is a dearth of faculty available for teaching especially the ADHP model. As I said, we do not have a dog in this fight. We are going to teach what state legislators and federal legislators tells us to teach relative to what model is accepted but you do put your finger on a significant challenge and that is who is going to teach this new model of workforce? I do not have the

answer other than to say it is challenge and it is an issue that is going to have to addressed if this model moves forward.

PHIL LEROY: Hi, my name is Phil Leroy [misspelled?] and I am from New York University College of Dentistry and I am a third year dental student. I actually have a question to him. My question is to Mr. Jack Bresch, ADEA. Where did the curriculum for ADHP been developed or reviewed? And if it is reviewed who is reviewing it? And the Masters Levels Course of ADHP Program what will it be containing of? Will it be a diagnosis oriented extensive courses or will it be clinical specialty like dental students do in residency?

JACK BRESCH, DIRECTOR, AMERICAN DENTAL EDUCATION ASSOCIATION: Would you like to repeat that question?

PHIL LEROY: The Master's Level ADHP course whether it will be diagnoses oriented extensive course or it will be clinical specialty?

JACK BRESCH, DIRECTOR, AMERICAN DENTAL EDUCATION ASSOCIATION: I do think that the question should be addressed more properly to the American Dental Hygienist Association. They are the ones who proposed this workforce model, they are the ones who have created it and our role as I mentioned at least twice is not to support any particular model but to teach whatever model is approved.

PHIL LEROY: Thank you.

HARRY GOODMAN, DIRECTOR OF ORAL HEALTH, STATE OF MARYLAND: Jack, where are you going to get the faculty the shortage of faculty now.

JACK BRESCH, DIRECTOR, AMERICAN DENTAL EDUCATION ASSOCIATION: Yes, in dental schools.

HARRY GOODMAN, DIRECTOR OF ORAL HEALTH, STATE OF MARYLAND: In dental schools. Are you engaged in some kind of development program that would produce new young faculty?

JACK BRESCH, DIRECTOR, AMERICAN DENTAL EDUCATION ASSOCIATION: It is a constant challenge. The lure of private practice, the financial lure of private practice is significant. The salary level of active admissions is certainly not at the level of private practicing professionals. We have attempted through a number of different ways to have faculty development to increase faculty loan development to forgive some loans to encourage students to look more closely at educational profession or career. In the present environment it is a significant challenge. Many of the vacancies while there are over 400 many of them are not being filled obviously and additional responsibilities are being burdened on the other faculty members. It is one that we have paid attention to but the total solution we have not yet found.

ED HOWARD, EXECUTIVE VICE PRESIDENT, ALLIANCE FOR HEALTH REFORM: Diane, final word?

DIANE ROWLAND, KAISER COMMISSION ON MEDICAID AND THE UNINSURED: I just want to thank all of our Panelists and all of you for what I think has been just the first step in our discussion of oral health and so Jack got us started and it took him this long to get us here I think we will be back very, very soon.

ED HOWARD, EXECUTIVE VICE PRESIDENT, ALLIANCE FOR HEALTH REFORM: Thank you all.

[END RECORDING]