



AAPD Position Statement
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IOM Oral Health Access Committee
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Thank you for the opportunity to provide this statement on behalf of the American Academy of Pediatric Dentistry.

I'd like to begin with a brief perspective on oral health care for children. You're probably aware that the dominant focus of oral health care for children relates to the diagnosis, prevention and treatment of tooth decay (dental caries). Caries is a chronic, complex, transmissible disease which is acquired early in life. As with many chronic diseases, caries can be controlled or managed at the level of individuals by achieving a balance between various risk factors and protective factors. The severity and impact of dental caries can be mitigated via healthy habits (sound nutrition, fluoride toothpaste), fluoridated water, and clinical services (fluorides, sealants, antimicrobials), especially with consistent use of these measures over time. However it's important to remember that although cavities can be prevented, caries must be managed on an ongoing basis!

Caries management and maintenance of good oral health are best achieved through effective self-care and ongoing professional care arrangements that combine periodic clinical examinations, risk assessments, education and counseling, disease management, and restoration of damaged structures according to professional guidelines (ideally evidence-based). These observations are the foundation of the dental home concept. Studies in high-risk populations have demonstrated that implementation of this approach in young children produces better oral health and can reduce the costs of both dental and medical care.

AAPD has been the leading advocate for the dental home concept and early initiation of dental care ("the age-1 dental visit"), and is the primary source of clinical guidelines and policies

related to children's oral health (published annually in our AAPD Reference Manual). I also would like to point out that federal agencies have sought out AAPD leadership on numerous occasions in the development of Medicaid policy (*CMS Guide to Children's Dental Care in Medicaid*) and performance measures concerning pediatric oral health (NCQA Pediatric Oral Health Performance Measure Recommendations).

The vast majority of dental services for children are provided by private sector dentists in the U.S. -- approximately 70% by general dentists (who comprise roughly 80% of all dentists) and at least 30% by pediatric dentists (who comprise only 2%-3% of all dentists). And while pediatric dentists provide lots of 'well-child care' dentistry, they also provide a large portion of care for children with early childhood caries, those who present behavior challenges, children with special health care needs, and children covered by Medicaid.

Primary care physicians and community allied dental health professionals (e.g., dental hygienists) provide education and preventive oral health services which can help reduce disease levels. As such, they serve as valuable adjuncts or complements, but not substitutes for comprehensive dental care provided in a dental home by or under the supervision of a dentist (especially true for high-risk or vulnerable children).

Public sector dental providers serve an important role in dental care delivery for 'vulnerable' populations, but provide a very small portion of all dental services, and face chronic recruitment and retention challenges. Doubling or tripling the current 'safety net' output level would require overcoming long-standing political and economic challenges and working within the context of established human preferences for certain geographic locations, and still would likely have only a limited effect on service delivery. Private sector dentists have been shown to deliver care with high efficiency, especially when maximum use is made of allied dental personnel working as part of teams and integrated systems of care, but often choose to limit the availability of their services.

Faced with these realities, focusing predominantly on 'safety net providers' seems somewhat ill-advised. It would seem more prudent to work toward developing integrated systems of care through public-private partnerships that capitalize on the strengths of both the private and public sectors, address recognized deficiencies in each sector via specific strategies, and emphasize

team-based approaches that are sensitive to diverse community environments. That is exactly what AAPD is working to accomplish in every state throughout the nation in partnership with the Office of Head Start through our Head Start Dental Home Initiative -- working with professional partners both in dentistry and medicine; Medicaid and public health officials; Head Start program staff at federal, state and local levels; early childhood education specialists; nutritional programs such as WIC; and countless others who care about children's oral health. (And we're continuing to learn a great deal in the process.) AAPD (whose members include general dentists as well as pediatric dentists) also continues to work with our medical colleagues to enhance the interface between medical homes and dental homes, and with government agencies and other professional organizations to foster improvements in prenatal and perinatal oral health care.

Despite longstanding efforts, significant disparities in dental disease and access to care by household income, race/ethnicity, parents' education, parents' oral health (especially mothers) and payor source persist. Debates about the factors responsible for these disparities generally center on differences of opinion about whether the underlying problem relates to:

- Medicaid program funding, reimbursement and program administration OR providers' unwillingness to treat certain types of patients?
- The supply of services/not enough providers OR not enough providers in certain places?
- Access to services OR demand for services?
- Patient education OR provider education?
- Lack of education OR lack of motivation?

Clearly, there are no shortages of ideas, opinions, 'fads', or 'answers' from other countries . . . but those who truly understand and have experience with dental disease in children and issues related to oral health and dental care delivery, also know that there are no simple, quick, easy or cheap solutions. Improvements must be made on many fronts using evidenced gleaned from real-world, U.S. circumstances, not untested hypothetical extrapolations of experiences in dissimilar contexts.

Which brings us to the work of this IOM committee, and charges that call upon you to "describe a desired vision for the oral health care system and recommend strategies to achieve that vision" ... "with a specific focus on the provision of oral health services to women and children." AAPD remains deeply disappointed and disturbed that those responsible for assembling this

committee did not see fit to include one or more pediatric dentists who could provide valuable -- we would go so far as to say essential -- insights gained from direct clinical experience, knowledge of relevant science and policies, and involvement in a broad range of program and policy arenas as members of this committee. Not as a representative of any organization, but to provide needed expertise. Surely the IOM would not conduct a study of childhood asthma care or mental health care without one, and probably several pediatricians; why should it be different for childhood oral health care?

In closing, thank you again for the opportunity to present AAPD's position. The Academy stands ready to support the work of this committee, but implores the IOM to address this critical void and reconsider adding one or more pediatric dentists who have the requisite clinical, program and policy expertise and experience to the committee.