

Dr. Halpern's Testimony before the IOM Oral Health Access to Services Committee

March 4, 2010

Good morning. I am Dr. David Halpern and I am the President of the Academy of General Dentistry. The AGD is the second largest dental association in the world and represents 35,000 general dentists in the United States. By way of introduction, I am a full-time general dentist and own a practice in Columbia, Maryland. I graduated from Fairleigh Dickinson University School of Dentistry in 1978 and completed a General Practice Residency at Sinai Hospital of Baltimore, Md. in 1979; since 1982 I have been in private practice.

I am a solo practitioner and work closely with two full time dental assistants and two full time dental hygienists. Our practice sees close to 5000 patients and delivers close to 20,000 dental procedures yearly.

Speaking for myself, and on behalf of the AGD, I want to take this opportunity to reiterate the profession's disappointment and concern in the lack of a practicing dentist on this Committee.

Let me be clear that I know that no organization was in any way guaranteed a spot on this committee. However, it is extremely disconcerting that the American Dental Association, which is the umbrella organization representing all of dentistry, the AGD, which represents general dentists, and the American Academy of Pediatric Dentistry, which represents pediatric dentists, all submitted names for consideration for appointment to this Committee. Yet, not one of any of our organizations' well-qualified nominees were selected to be on this study committee.

In contrast, the American Dental Education Association, which represents the dental schools and academia, submitted a list of names for consideration, and had not one but two of its supported nominees be appointed between this Committee and the Study Committee for an Oral Health Initiative.

Over 90% of all practicing dentists are in the private sector and over 80% of dentists are primary care providers. For this committee to lack representation from the private sector totally deprives the study of real world input, and totally goes against the committee's charge of reaching a balanced, objective, and credible conclusion.

It is so important to have a primary care practicing dentist on this committee because of the discussions that you will be having regarding a desired vision for the oral health care system. As we all can acknowledge, there has been an effort from certain groups to foster the belief that expanding the oral health care delivery workforce through the creation of a midlevel dental care practitioner can improve access to care. The premise purported is that through providing basic, primary services, the additional care provider permits the dentist to devote more time to complex therapy that only a dentist is trained and qualified to provide.

Frankly this is precisely what is already occurring in the current dental team model, in my practice and throughout the country. My properly trained assistants, under my supervision provide services to our patients which allows me the opportunity to see additional other patients simultaneously. There are numerous procedures which they could be additionally performing if allowed by my state's dental law. The disparate nature of dental laws from state to state is in part the reason for disparate access to care statistics, a study of which would be important to the charge of this committee as well.

Due to this committee's charge to examine issues that affect underserved populations that are most vulnerable to oral disease you will no doubt be having discussions on related to workforce utilization. This is EXACTLY the reason why the voice of a primary care practicing dentist must be heard. WE are the ones who understand the importance of protecting the public. We are the ones who see the patients and, see what happens when something goes wrong, and who have the requisite education to deal with those complications. This is why the dentist has the responsibility of overseeing the dental team and why the dental team concept is so important to preserve. Any delivery system that offers less than the best is unacceptable for the general public's health and welfare. To those whose hands aren't in a patient's mouth every day, alternative delivery models look good in theory, but they are unlikely to be able to answer the question of not only whether they actually work in practice, but if they are truly also cost effective, and not just cost delaying.

Should the opportunity present itself to alter the committee structure, as the spokesperson for the Academy of General Dentistry, I would strongly endorse that consideration; please correct the current oversight by adding individuals from the private sector.

That said, I thank this Committee for the opportunity to present before it, and will now briefly provide direction on two of the four tasks before you as set forth in your Statement of Task.

Task #1 – Assess the current oral health care system

1. Today, the Health Resources and Services Administration (HRSA) defines a Health Professional Shortage Area (HPSA) in dentistry, generally, as an area with more than 5000 patients per dentist. Moreover, studies have shown that dental practices fully-staffed with auxiliaries may increase capacity 1.5 fold. However, actual dentist to patient ratios vary by state, region and locality from less than 1000 patients per dentist to over 3000 patients per dentist. The fact remains that dental homes staffed with dentists and auxiliaries have significant capacity to see numerous additional patients; the real challenge is not one of capacity of the dental office but of creating access to the dentist and increasing utilization by the patient.
2. Moreover, according to Dr. Eric Solomon's report entitled, *Dental Workforce*, and released just last year, only 10% of dentists employed a hygienist in 1955, while 74% of dentists employed a hygienist in 2000. According to the report, "This increase in the use of dental hygienists follows the shift toward **more preventive**

- services, a higher percentage of the population receiving routine dental care, and a general decline in the caries rate.”**
3. We must be mindful of the fact that some areas have a shortage of hygienists in the dental practice. A 2005 study by the UCLA Center for Health Policy Research found that 52% of dentists reported having a need for additional hygienists in their practice and 47% of these dentists reported challenges in filling the positions within their offices.
 4. Further, hygienists have attained the unique and special educational training in the field of prevention, hygiene, and periodontal treatment modalities which are much needed within the dental practice; actions that result in the removal of hygienists from the current workforce model can have a hugely detrimental impact on the leaps and bounds we have made in making prevention the cornerstone of dentistry.
 5. Of course, we understand your concerns about cost when considering capacity. Dr. Solomon’s report states that dental expenditures have increased from \$10.86 per capita in 1960 to \$305.20 per capita in 2006, noting an increase in cost of 7.4% per year. However, only one-third of the population visited a dentist annually in 1960 while two-thirds of the population visited a dentist in 2006. Therefore, the increase in cost must be halved to reflect accuracy, and is therefore not significantly greater than cost increases in the general marketplace.
 6. Moreover, the assumption that the creation of new providers of care will reduce cost of dental care by doing procedures at a reduced fee is presently unproven and we believe a premise that is flawed.

Task #4 – Strategic plan for improving the oral health of women and children

1. Now, addressing task #4, the caring for the oral of women and children in underserved areas, we absolutely must be mindful that there is a reason that Commission on Dental Accreditation (CODA) has established minimal educational standards for a DDS or DMD. This is the minimum education needed for competence in performing unsupervised dentistry.
2. When considering these vulnerable populations, including women and children, we should not then consider even lesser than the minimal education for those who provide the primary oral health care. If anything, vulnerable populations and those with other systemic considerations, such as pregnancy, deserve care by dentists who have greater education. Dental schools are already struggling to fit the volume of courses that meet minimal competency requirements into their four-year programs. General Practice Residency (or GPR) and Advanced Education in General Dentistry (or AEGD) programs enhance dentists’ skill sets and proficiency to better enable and empower dentists to assist the most vulnerable populations and therefore, these programs must be considered as key components of the solution to access to care for women and children.

In closing, I’d like to reiterate that numerous solutions already have been proposed by us and other dental organizations to resolve the access to care issue by promoting modalities

that allow properly licensed well-trained dentists and their current team to care for the oral health of vulnerable populations. You all know about the AGD Access to Care White Paper. However, we **NEED YOUR HELP** to further its message – the solutions are there, the funding is not – we need your collaboration and help – we need you to coordinate with our efforts in solving access to care because we can't do it alone! Now is not the time for experimentation with new models– now is the time for funding and for action in expanding what we know works – the dental home with dentists, assistants and hygienists bringing what has worked for so many to the presently underserved populations to solve access to care! Thank you!