

ORAL TESTIMONY

Of

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President of the American Dental Association

IOM Hearing

Committee on Oral Health Access to Services

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Good afternoon, I am Dr. Ron Tankersley, the president of the American Dental Association. The ADA membership includes over 157,000 dentists—who practice in both private and public settings—and represents nearly 70 percent of the profession.

Before I begin, I am obligated, on behalf of our members, to protest the IOM's continuing failure to include representatives of the private practice dental community on either of its two oral health panels. We respect the experience and knowledge of the committee members. But the nation's 167,000 private practice dentists represent some 92 percent of professionally active dentists in the U.S. Without them, there can be no significant impact on access to oral health care, regardless of the delivery system.

I also want to register our constituents' unease with this panel's conducting so much of its business behind closed doors. This committee cannot, through a few minutes of testimony, hear enough from those who are in the field delivering care to inform its decisions.

Improving access to oral health services for underserved members of our society has been a primary goal of the ADA for years. In fact, volunteers and staff on the Council on Access, Prevention and Interprofessional Relations, known by its acronym CAPIR, devote much of their time and resources toward this goal. The ADA believes that oral health depends on *preventing* oral disease. The nation will never drill and fill its way out this problem.

The CAPIR staff includes a former dental director for the state of Illinois and president of the Association for State and Territorial Dental Directors (ASTDD), a retired HRSA regional dental consultant, dental hygienists with expertise in prevention and health promotion, and a hygienist with a PhD in epidemiology who has significant experience addressing the oral health needs of geriatric and special needs populations. My point here is that between volunteers and staff, CAPIR's combined experience in working to increase access for the underserved may exceed that of this committee.

Our efforts to improve access to care have taught us that there are many contributing factors and barriers to the problem. Some are economic and others environmental; some are direct and others indirect; some are related to the individual and others to the provider.

The ADA has been on the vanguard of advocating access solutions, including:

- Designing and implementing a pilot program for its prevention-focused Community Dental Health Coordinator, a community health worker with dental skills now active in Philadelphia, rural Oklahoma and Indian tribal areas;**
- Convening an Access to Dental Care Summit in 2009 for a broad range of 144 stakeholders to identify short- and long-term ways to improve oral health for underserved populations;**
- Creating a Public Health Advisory Committee to provide a formal presence within the ADA to receive input on issues of public health significance;**
- Convening the 2007 American Indian/Alaska Native summit to collaboratively address the unique needs of these populations;**
- Implementing an association-wide initiative to address oral health needs of the vulnerable elderly, one outcome of which will be the introduction of federal legislation;**

- **Seeking to increase collaboration among private practice dentists and those working in Federally Qualified Health Centers and other dental safety-net clinics, where about 69 percent of the dentists are members of the ADA; and**
- **Lobbying for virtually every federal program that could effectively improve access for the dentally underserved.**

Time constraints limit me to only a brief overview of how the ADA is helping to meet the challenges we all face, and how we all can work together to improve the lot of the dentally underserved. We also will submit written testimony with greater detail.

While the current dental delivery system serves most Americans well, we must work together to extend that system to the most vulnerable among us, who are at the greatest risk for developing oral disease. The ADA believes that the most effective ways to accomplish this are

- 1) to rebuild the public health infrastructure and expand and adequately fund safety-net programs (including Medicaid),**
- 2) increase community-based prevention programs, and**
- 3) improve oral health literacy.**

Our current dental public health infrastructure is insufficient to address the needs of the underserved. And the gap between needs and the ability to address those needs is growing.

State and local health departments have for decades suffered a continual erosion of their dental programs due to neglect by both state and federal policymakers.

A perfect example is the New York City health department, which has been forced to close a number of school-based dental clinics due to budget problems, cutting or reducing services to about 17,000 students.

Some people ask, “Why do so few dentists participate in Medicaid,” but the question should be, “How long can they continue to do so?”

Of the 50 states and District of Columbia, only nine have what could fairly be called full dental Medicaid coverage for adults. Eighteen have what we consider a limited benefit package. Sixteen cover only emergencies. And eight states have no adult benefits at all. Michigan and Utah have recently eliminated adult services, and California curtailed its adult program to cover only pregnant women.

And many states are considering across-the-board fee cuts for all private sector providers, which can only further erode the system.

Things are just as bad at the federal level. For instance, at one time the Health Resources and Services Administration had 10 full-time regional dental consultants – now it has none. The Centers for Disease Control and Prevention can fund oral health infrastructure grants this year for only 16 of the 32 states that applied.

Prevention is the key to improving and maintaining oral health. Community-based prevention initiatives such as water fluoridation, school-based screening and sealant programs are proven and cost-effective measures. The ADA, with guidance from our National Fluoridation Advisory Committee, has developed resources and provides technical assistance to support dentists and coalitions in their efforts to start and retain fluoridation at both the local and state levels.

In November 2009, the ADA published updated recommendations and reviews of evidence for preventing dental caries through school-based sealant programs, which were developed by a workgroup convened by the CDC Division of Oral Health.

In addition, the ADA is currently pilot testing—and funding—a potential new member of the dental team, the Community Dental Health Coordinator or CDHC, which I mentioned earlier. CDHCs will focus on education, prevention and assisting people who otherwise might not be able to navigate the oral health care system. Serving as a community health worker with oral health skills, and operating under the supervision of a dentist, the CDHC will enable the existing dental workforce to expand its reach deep into underserved communities and influence local health and community organizations to adopt initiatives to promote oral health. The CDHCs model is being tested now in urban, rural, and American Indian communities.

People with low health literacy are often less likely to seek preventive care, comply with prescribed treatment and maintain self-care regimens that are necessary to control chronic diseases. Through our National Oral Health Literacy Advisory Committee, the ADA has developed a five-year National Action Plan, which begins this year, to improve oral health literacy.

This plan aligns with the Surgeon Generals' Call to Action and the draft National Action Plan to Improve Health Literacy developed by the Department of Health and Human Services and the CDC.

Finally, I will address the issue of workforce capacity. There are three things you need to keep in mind:

- 1. Many dentists have excess capacity in their practices right now, and operational efficiencies continue to increase their capacity to treat more patients.**
- 2. Some contend that there are not enough dentists to meet demand. We disagree. Michigan dramatically improved access in rural communities under the Healthy Kids Dental program without adding a single new dentist. Under this program the participation of dentists in Medicaid went from 20 percent to 90 percent. Over 2,000 new dentists joined the program without expanding the workforce. Additionally, the distance between providers was cut in half – making it easier for patients to access care. The typical dentist in the program added over 50**

Medicaid-enrolled patients to his/her practice. Programs such as this should be expanded into both rural and urban areas.

New dental schools have opened and the American Dental Education Association anticipates 10 additional new schools by 2022. A majority of these schools use community-based sites for clinical instruction to promote cultural competency and prepare students for caring for underserved populations.

- 3. Creating new dental models without the input and support of dentists is a grave mistake that could result in a fractured and misaligned public health infrastructure. A virtual “caste system” of dental care will emerge that continues to shortchange those whose cases are the most complex and who need comprehensive care from a fully qualified dentist.**

In closing, I will urge the committee again to reconsider its decisions to conduct its business behind closed doors and exclude the private practice community from representation. The latter is tantamount to forming a panel on air traffic safety and excluding pilots.

I thank you for your time and attention and look forward to answering your questions.