

1 **OPTIONS FOR IMPROVING ORAL HEALTH CARE IN NORTH DAKOTA**

2 **Testimony of Bradley J. Anderson, DDS** 3 **North Dakota Legislative Management Health Services Committee** 4 **Thursday, April 24, 2014**

6 ***Background***

7 Thank you for having me here today. My name is Brad Anderson. I am a general dentist, and I
8 have been practicing in Fargo since graduating from the University of Minnesota School Of
9 Dentistry in 2009. The issue of accessing oral health care in North Dakota is intricate and
10 complex. There are many factors that lead to systemic lack of care, including a lack of oral
11 health literacy and psychological factors, not just the financial and provider distribution issues
12 normally referenced.

13
14 The Academy of General Dentistry (AGD), the second largest dental organization in the United
15 States, and the North Dakota Academy of General Dentistry have long been proponents of
16 removing the barriers that limit the underserved from seeking and receiving quality oral health
17 care. In 2013, the AGD's language on improving oral health literacy was adopted as a model
18 resolution by the American Legislative Exchange Council (ALEC). This year, we are proposing
19 model language to provide scholarships for dental students that commit to practice in
20 underserved areas. The language for both of these model bills is included in my testimony
21 materials.

22
23 In 2008, the AGD created its first white paper on oral health care issues, "*White Paper on*
24 *Increasing Access to and Utilization of Oral Health Care Services.*" This was followed in 2012
25 by "*Barriers and Solutions to Accessing Care.*" These two documents outline the challenges to
26 bettering the state of oral health, and provide over 30 proven solutions to increasing care. I would
27 like to talk about some of those solutions today. Specifically, I'll focus on: 1) oral health literacy;
28 2) turning literacy into action; and 3) bridging geographical gaps between dentist and patient.

30 ***Oral Health Literacy***

31 The public remains largely unaware of the connection between oral health and overall health and
32 well-being. Oral disease left untreated can result in pain, disfigurement, loss of school and work
33 days, nutrition problems, expensive emergency department use for preventable dental conditions,
34 and even death. Reducing the incidence of dental disease among America's children through oral health
35 literacy needs to be embraced by North Dakota, since it will boost students' academic performance,
36 improve their overall health, and lessen the burden of parents, caregivers, and the dental Medicaid system.

37 The AGD calls for collaboration from all oral health stakeholders to:

- 38 - Develop a comprehensive oral health education component for public schools' health
- 39 curriculums;
- 40 - Provide oral health exams for one-year-olds to help facilitate early screenings; and

- 1 - Equip teachers and day care providers with creative educational tools on the importance
2 of oral health;

3
4 To this end, the AGD joined Partnership for Healthy Mouths Healthy Lives and the Ad Council
5 to create an ad campaign on teaching children to brush at least two times a day for two minutes
6 each time. Samples of the materials for this campaign are included in my testimony materials.
7

8 ***Turning Literacy into Action***

9 As lawmakers, I'm sure you know that understanding an issue and acting on it are two different
10 things. Likewise, a patient's awareness of the importance of his or her oral health is not the same
11 as actually seeking or receiving care. The AGD understands that we need to turn oral health
12 literacy into healthy behaviors and patient action. Education must be coupled with dealing with
13 the psychological factors that may inhibit some from seeking oral health care. This includes:

- 14 - Helping the public understand that, unlike many medical ailments, the most prevalent
15 dental diseases are entirely preventable, and prevention is cheap. This can be described as
16 the difference between a *prevention model* in oral health care, versus a *treatment*
17 *mentality* in traditional medical health care. A prevention model encourages regular
18 check-ups to detect problems before they become bigger, more costly difficulties.
19 - Ensuring that healthcare delivery considers cultural diversities that might affect patient
20 perceptions.
21 - Establishing patient navigators within communities to provide hands-on education about
22 oral health and provide social services, including transportation, to convert health literacy
23 into action. However, using navigators to provide clinical services must be prohibited
24 because it is unnecessary, it creates a needless risk to the patient, and it adds to the cost of
25 training the navigator.
26

27 ***Bridging Geographical Gaps Between Dentist and Patient***

28 What is important to understand is that there is no shortage of dentists. However, uneven
29 geographical distributions of dental practices may give the incorrect impression of a shortage.
30 The fact is, with the influx of new dental schools, new dentists are seeking employment and
31 established dentists are seeking patients. Where a true environmental scan reveals a chasm
32 between the geography of supply and the geography of demand, our calling must be to bridge
33 that gap.
34

35 There is a variety of programs to bring dentists to areas of the state that do not have practicing
36 full-time dentists. Since 2001, North Dakota has offered a Dental Loan Repayment Program for
37 dental students to practice in areas of the state where there is no dentist upon graduation. Over 30
38 dentists have taken advantage of this program and practice in counties considered Health
39 Professional Shortage Areas (HPSA).¹ The AGD supports such programs.

¹ Dental Services Study - [Background Memorandum](#)

1
2 However, the AGD also understands that other factors must be considered when talking about
3 underserved areas of the state. The issue is not just about a lack of dentists in a particular county,
4 but also about practice capacity. Sparsely-populated counties, such as those with fewer than
5 1,000 residents, would be better-served by mobile dental units, provision of transportation
6 services, community health clinics and use of patient navigators.
7

8 Some have argued that the solution to bridging the divide is to have non-dentists provide dental
9 care for the poor. Setting aside for a moment the moral indignation in creating two tiers of care
10 with non-dentists for the poor and dentists for everyone else, relegating these alternative
11 providers to underserved areas is also financially unsustainable. In a December, 2013 webinar by
12 the National Conference of State Legislatures and Pew, Minnesota state representative Kim
13 Norton commented that the new dental therapists are not moving to the rural areas of the state, as
14 had been predicted when the legislation was enacted in 2009. Additionally, a 2005 ADA study²
15 revealed that, when provided the opportunity to practice in underserved areas without the
16 physical presence of dentists, alternative non-dentist providers nonetheless flee to wealthier
17 neighborhoods, driven by the inability to cover overhead costs.

18 On the other hand, the AGD supports proven solutions of establishing oral health care delivery
19 service programs, including arranging for transportation to and from care centers, mobile
20 dentistry units and soliciting volunteer participation from the private sector, through programs
21 such as Missions of Mercy (MoM).
22

23 **Conclusion**

24 As the North Dakota legislature seeks out solutions to the issue of improving oral health care for
25 all North Dakota residents, the AGD stands ready to work with you. The matter is complex, and
26 the AGD applauds the Health Services Committee for tackling the issue. There are a variety of
27 ways to combat the current barriers to better oral health care, including oral health literacy,
28 dental loan repayment options, and breaking down the psychological factors that keep people
29 from seeing a dentist.
30

31 The AGD is working to bring some of those options to North Dakota, and across the nation,
32 through our White Papers, model legislation and Ad Council participation. Additionally, I have
33 attached a figure that provides a sample visual depiction of the administration of a prevention
34 model using a ‘dental team concept.’
35

36 The bottom line is that we must remain focused on the best interest of the patients. Dentistry
37 works best as a prevention system, with a dental team providing care from start to finish.

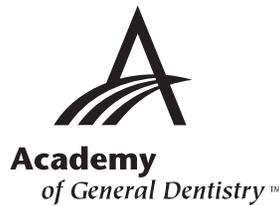
² Brown, L.J., House, D.R., & Nash, K.D. *The Economic Aspects of Private Unsupervised Hygiene Practice and Its Impact on Access to Care*. Dental Health Policy Analysis Series. American Dental Association, 2005.



Academy
of General Dentistry™

**WHITE PAPER ON INCREASING ACCESS TO AND
UTILIZATION OF ORAL HEALTH CARE SERVICES**

“to serve and protect the oral health of the public”



White Paper on Increasing Access to and Utilization of Oral Health Care Services

EXECUTIVE SUMMARY

While patients who have availed themselves of dental services in the United States have enjoyed the highest quality dental care in the world, many patients are underserved presently, thereby raising the need to address both access to care and utilization of care. Access to care refers to the availability of quality care, and utilization of care refers to the behavior and understanding necessary by patients to seek care that is accessible.

Illnesses related to oral health result in 6.1 million days of bed disability, 12.7 million days of restricted activity, and 20.5 million lost workdays each year.¹ However, unlike medical treatments, the vast majority of oral health treatments are preventable through the prevention model of oral health literacy, sound hygiene and preventive care available through the dental team concept.

However, present efforts to institute independent mid-level providers—lesser-educated providers who are not dentists—to provide unsupervised care to underserved patients are not only economically unfeasible but also work against the prevention model. Because underserved patients often exhibit a greater degree of complications and other systemic health conditions, the use of lesser-educated providers risks jeopardizing the patients' health and safety. This approach will provide lesser-quality care to the poor.

Instead, solving the access to and utilization of care issues, thereby bridging the gap between the 'haves' and the 'have-nots,' requires collaboration among professional organizations; local, state, and federal governments; community organizations; and other private entities. This collaboration must strive toward a multi-faceted approach that focuses on oral health literacy; incentives to promote dentistry and dental teams in underserved areas (including through increased Medicaid and Title VII funding); provision of volunteer services through programs, such as Donated Dental Services (DDS); and bridging the divide between patients' access and utilization through the use of community services like transportation to indigent populations.

Specifically, the AGD's proposed solutions to the access to and the utilization of oral health care issues include, but are not limited to:

1. Extend the period over which student loans are forgiven to 10 years without tax liabilities for the amount forgiven in any year;
2. Provide tax credits for establishing and operating a dental practice in an underserved area;²

¹ U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2000. NIH publication 00-4713. Available from: <http://www.surgeongeneral.gov/library/oralhealth/>

² "The Maine Dental Association's own bill, called 'An Act to Increase Access to Dental Care,' has become law. Starting next year, dentists will

3. Offer scholarships to dental students in exchange for committing to serve in an underserved area;
4. Increase funding of and statutory support for expanded loan repayment programs (LRPs);
5. Provide federal loan guarantees and/or grants for the purchase of dental equipment and materials;
6. Increase appropriations for funding an increase in the number of dentists serving in the National Health Service Corps and other federal programs, such as the Indian Health Service (IHS), programs serving other disadvantaged populations and U.S. Department of Health and Human Services (HHS)-wide loan repayment authorities;
7. Actively recruit applicants for dental schools from underserved areas;
8. Assure funding for Title VII general practice residency (GPR) and pediatric dentistry residencies;
9. Take steps to facilitate effective compliance with government-funded dental care programs to achieve optimum oral health outcomes for indigent populations:
 - a. Raise Medicaid fees to at least the 75th percentile of dentists' actual fees;
 - b. Eliminate extraneous paperwork;
 - c. Facilitate e-filing;
 - d. Simplify Medicaid rules;
 - e. Mandate prompt reimbursement;
 - f. Educate Medicaid officials regarding the unique nature of dentistry;
 - g. Provide block federal grants to states for innovative programs;
 - h. Require mandatory annual dental examinations for children entering school (analogous to immunizations) to determine their oral health status;
 - i. Encourage culturally competent education of patients in proper oral hygiene and in the importance of keeping scheduled appointments;
 - j. Utilize case management to ensure that the patients are brought to the dental office; and
 - k. Increase general dentists' understanding of the benefits of treating indigent populations.
10. Establish alternative oral health care delivery service units;
11. Provide exams for one-year-old children as part of the recommendations for new mothers to facilitate early screening;
12. Provide oral health care, education, and preventive programs in schools;
13. Arrange for transportation to and from care centers; and

be eligible to receive up to \$15,000 in income tax credit annually for up to five years as long as they practice in underserved areas. The law currently limits participation in the program to five dentists, but the legislature will review its effectiveness in two years, and may then amend it to increase the number of allowed participants." American Dental Association (ADA) Update, June 10, 2008 (Retrievable from www.ada.org).

14. Solicit volunteer participation from the private sector to staff the centers.
15. Encourage private organizations, such as Donated Dental Services (DDS), fraternal organizations and religious groups, to establish and provide service;
16. Provide mobile and portable dental units to service the underserved and indigent of all age groups;
17. Identify educational resources for dentists on how to provide care to pediatric and special needs patients and increase AGD dentist participation;
18. Provide information to dentists and their staffs on cultural diversity issues which will help them reduce or eliminate barriers to clear communication and enhance understanding of treatment and treatment options;
19. Pursue development of a comprehensive oral health education component for public schools' health curricula in addition to providing editorial and consultative services to primary and secondary school textbook publishers;
20. Increase the supply of dental assistants and dental hygienists to engage in prevention efforts within the dental team;
21. Expand the role of auxiliaries within the dental team that includes a dentist or is under the direct supervision of a dentist;
22. Eliminate barriers and expand the role that retired dentists can play in providing service to indigent populations;
23. Strengthen alliances with the American Dental Education Association (ADEA) and other professional organizations such as the Association of State and Territorial Health Officials (ASTHO), the Association of State and Territorial Dental Directors (ASTDD), the National Association of Local Boards of Health (NALBOH) and the National Association of County & City Health Officials (NACCHO);
24. Lobby for and support efforts at building the public health infrastructure by using and leveraging funds that are available for uses other than oral health; and
25. Increase funding for fluoride monitoring and surveillance programs, as well as for the development and promotion of a new fluoride infrastructure.

ACADEMY OF GENERAL DENTISTRY (AGD) WHITE PAPER ON INCREASING ACCESS TO AND UTILIZATION OF ORAL HEALTH CARE SERVICES

I. Introduction

Patients who utilize the services of dentists in the United States enjoy the highest quality dental care in the world. Dentistry is paid for primarily with private sector dollars. In 2004, for example, state, local, and federal government programs paid less than \$4.9 billion for dental care compared with \$81.5 billion paid through personal health care expenditures, such as out-of-pocket payments, third-party payments, or private health insurance.³

Among the health professions, dentistry is singularly oriented toward **preventive health**. The National Institute of Dental and Craniofacial Research (NIDCR) estimates that dentistry's emphasis on preventive oral health measures saved nearly \$39 billion during the 1980s. In addition, the Centers for Disease Control and Prevention (CDC) said in an August 2000 letter to Congress that community water fluoridation, which was introduced in public water supplies in the 1940s to help prevent tooth decay, is "one of the greatest public health achievements of the 20th century."

³ The Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group (2004).

Despite dentistry's successes, significant challenges lie ahead. Two of the biggest challenges in achieving optimal health for all are: 1) **underutilization of available oral health care**; and 2) **maldistribution⁴ in areas of greatest need**.

Access to care and utilization of care must be addressed from the perspective of patient needs, especially the needs of underserved patients who are in greatest need of competent care and exhibit complications and systemic health issues. The Academy of General Dentistry (AGD) is very mindful of the Surgeon General's report (*Oral Health in America: A Report of the Surgeon General*) that stated that oral health care is intimately related to systemic health care. These patients include the indigent, children, rural populations, the developmentally disabled, elderly/nursing home patients, the medically compromised and transient/non-English speaking populations.

Further, the profession must address other challenges, including non-economic barriers to access and utilization such as patients' behavioral factors, levels of oral health literacy, special needs, financial factors, two-tiered systems of delivery (poor quality care for the poor), maldistribution of dentists and dental team auxiliaries, transportation, location and cultural/linguistic preferences.

The profession is eager to work with private sector groups, community organizations, teaching facilities, U.S. Public Health Service Corps (Corps), Indian Health Service (IHS) and state, local and federal lawmakers to increase oral health literacy to these populations, reduce disparities in oral health status and increase access to and utilization of oral health care services, thereby reducing the incidence of dental disease and associated systemic ailments.

II. Definitions

Access to Oral Health Care Services (Access to Care)—The ability of an individual to obtain dental care, recognizing and addressing the unique barriers encountered by an individual seeking dental care, including the patient's perceived need for care, oral health literacy, dentist and dental team distribution, financial circumstances, special needs, transportation, location, language, cultural preferences and other factors influencing entry into the dental care system.

Independent Mid-Level Provider⁵—A dental auxiliary, working outside the dental team and without dentist supervision, who accepts the responsibility for patient diagnosis, treatment and coordination of dental services with less education than what is currently required for a practicing dentist.

Oral Health Literacy—The degree to which individuals have the capacity to obtain, process and understand basic oral health information and services needed to make appropriate oral health decisions.⁶

Underserved—Refers to patients including the poor/indigent, geographically isolated, medically compromised, transient/non-English speaking, developmentally disabled, nursing-home bound (and other institutionalized individuals), the elderly and children who have historically

⁴ The term "maldistribution," as used here and throughout this paper, does not imply or suggest an incorrect or wrongful distribution, but rather, the term is synonymous with an **uneven** distribution of dentists and dental teams in relation to the distribution of the presently underserved.

⁵ Currently there is no suitable definition for a "mid-level provider" within the dental team due to variations and inconsistencies in both the usage of the term "mid-level provider" in dentistry and the delegation of auxiliary duties by different states. **The independent practice of dentistry by non-dentists, outside the scope of the team concept, is a lower level of practice.**

⁶ Based on the definition provided by the *Healthy People 2010* report.

experienced lower or no utilization of oral health care services but often exhibit greater need for dental services. These individuals may also have concurrent co-morbidities that complicate treatment, and inadequate oral interventions may lead to unintended adverse medical outcomes.

Utilization of Oral Health Care Services (Utilization of Care)—The percentage of the population receiving oral health care services through attendance to oral health care providers, while taking into consideration factors including, but not limited to, health-related behaviors, oral health literacy, dentist and dental team distribution, financial circumstances, special needs, transportation, location, language, cultural preferences and other factors influencing entry into the dental care system.

III. The State of Oral Health in the United States

Dental disease is important because it impacts both children and adults physically, functionally, emotionally, and socially. It also affects the nation's productivity.

Oral Health Is Key to General Health

Oral health has not been treated as the important part of overall health that it is. A person cannot be healthy unless he or she also is healthy orally. The mouth can be the window to the rest of the body: it often reflects general health and well-being and can indicate disease and dysfunction. Oral infections can be the source of systemic disease. Individuals with weakened immune systems are especially vulnerable to severe systemic complication, sometimes life-threatening, from oral infections. In addition, research has found associations between chronic oral infections and other health problems, including diabetes, heart disease, and adverse pregnancy outcomes.

The need for dental care cannot be ignored. Unlike many medical conditions, dental problems are not self-limiting. Dental diseases become progressively more severe without treatment, requiring increasingly costly interventions. Initial disease attack, and the treatment required to manage it, often lead to sequela, which require more radical and invasive interventions later in life. On the other hand, **most dental diseases are prevented easily at little cost through regular examinations in conjunction with appropriate modern preventive modalities.** In addition, the initial recognition of life-threatening conditions like HIV infection and oral cancer are often made in the dental office.

Parents must understand that oral health is much less arduous and less costly when care is started early and maintained by the regular attendance of a dentist. All children need a dental home and continuous comprehensive care.

IV. Challenges to Access to and Utilization of Care

Increasing utilization of care requires a significant and concentrated effort toward increasing oral health literacy, especially among underserved populations. **Increased oral health literacy will allow individuals to see value and ask for services and will allow communities to develop a culture of oral health as a priority that they should work to achieve.** Further, increasing access to care requires a multifaceted solution to promote the practice of quality dentistry in underserved and rural areas and for those with intellectual and developmental disabilities, the elderly, children, the medically compromised and transient/non-English speaking populations. The dental profession is dedicated to working with governmental entities, community organizations, and other private entities to develop solutions to these problems and work toward these endeavors. Workable solutions to access, utilization, and the maldistribution of dentists and dental team auxiliaries are discussed further in Section V below.

THE INDEPENDENT MID-LEVEL PROVIDER

One present challenge to access to and utilization of care arises from within the profession itself and threatens not only to create a two-tiered system of delivery, providing poorer quality care for poor and medically needy populations, but also to divert economic resources from oral health literacy, expansion of quality care, correction of maldistribution, and, most importantly, the commitment to prevention.

Numerous organizations have introduced concepts for advanced training of a hygienist, other auxiliary or another non-dentist, to produce a less clinically and didactically trained provider, commonly referred to as a "mid-level provider." This individual will not have attained the minimum education and competency levels of a dentist but would diagnose, treat and/or manage the oral health of underserved populations *outside the support of a dental team and independent of a dentist's supervision.*

Subtracting from the Prevention Model

Dentistry focuses on preventive care. Therefore, the AGD supports the dental team concept as the best approach to providing the public with quality comprehensive dental care. Further, **the AGD recommends advanced training of auxiliaries to provide greater expertise of preventive care and of treatment within the dental team concept or under the direct supervision of a dentist.** The dental team concept provides the patient with a dental home for continuity of comprehensive care with a focus on prevention and treatment to forestall or mitigate the need for cost-ineffective critical care. It also best ensures that the patient will receive appropriate, competent and safe care.

Further, as stated above, the prevention model has produced not only health benefits to patient populations, but also economic benefits to the health care system. Past advances in the prevention and treatment of oral diseases have been estimated to generate savings of \$5 billion per year in dental expenditures alone. Dental expenditures in 2002 exceeded \$70 billion, the majority of which were associated with the repair of teeth and their surrounding tissues—and which could have been prevented by regular professional dental care and good home care instructions from the dentist and his/her staff. **Auxiliaries play the key role in patient education and preventive care within the dental team.**

The concept of independent mid-level providers subtracts from the prevention model as part of a comprehensive oral health umbrella of care to the detriment of access to and utilization of care. **Removing the oversight of the dentist removes the one professional who has the overall knowledge and training to coordinate all aspects of treatment that patients might need.**

First, concepts that propose the use of the auxiliary workforce to fuel the development of independent mid-level providers result only in the removal of auxiliaries from their preventive role within the dental team. Presently, **there is a clear maldistribution of hygienists within the dental team, with some regions of the United States experiencing a shortage.** The diversion of resources to create an independent mid-level provider will serve to further the maldistribution within the dental team and act as a disservice to disease prevention. The utilization of the auxiliary workforce within the team is an approach that can still be enhanced to maximize the benefit for the patients. Training and expanded functions within the dental team can easily increase the number of patients a dentist can treat in a comprehensive manner. Diverting auxiliaries into non-team areas has the opposite effect.

Second, prevention provided away from complete comprehensive care, including that of a dentist, **puts patients at risk** of receiving inappropriate

and possibly unsafe care. Patients cannot be expected to make fine distinctions between alternative treatment choices. They assume that the level of care that they receive is adequate and complete. A complete comprehensive care setting will have preventive education for the patients and their family, plus it will have the full complement of care and diagnosis by a dentist. Without a comprehensive care setting that includes the services of a dentist, duplication of services will become necessary.

Third, resources utilized to train independent practice hygienists or other independent mid-level providers could otherwise be directed toward **oral health literacy programs and recruitment and incentives for dentists to practice in underserved areas.**

Those funds could be used to increase the number of dentists being trained, as well as training for expanded duties assistants.

The shortage of faculty and teaching facilities is already critical and this infrastructure could not support the added requirement of teaching and time in training independent mid-level providers.

The development of a curriculum, which mirrors what is already being done but yields a less qualified product, is a poor fiscal policy and wastes precious dollars and resources.

Conflicts with Economic Realities

Independent mid-level providers will not be immune to the forces of supply and demand. They will likely find it **less economically feasible to maintain an independent practice in underserved areas.** The absence of a full-service, dentist-led practice will only compound their difficulties because they will still have to bear the financial burden of maintaining fully equipped, modern dental facilities and the resultant business risks of their investments. An ADA study revealed that, when provided the opportunity to practice independently to serve the needy, the overhead of maintaining a practice drives independent mid-level providers away from underserved areas. Presuming that the pilot study serves as a microcosm, the mid-level concept would fail to provide any indigent care, even care that falls short of the minimal standards of quality and safety.

Further, underserved areas may include remote rural areas or areas with high indigent populations who are most in need of dental care but are the least able to pay for it. The dental team concept, with the dentist in supervision of the practice, provides the hygienist with the economic protection and freedom to expand his or her practice to serve the needs of low-income populations through expanded services, such as the provision of hygiene education and case management services (especially in the public health setting).

Further, **the team concept provides the accessibility to the knowledge and resources needed to address complications and compromised systemic health conditions that often plague many of the underserved.** Without the direct supervision of a dentist, the independent mid-level provider will likely not find a dentist immediately accessible to address complications. Given the finding that there is a maldistribution of dentists in underserved areas, the independent mid-level provider's access to a dentist may meet the same challenge as the patient's direct access to and utilization of the services of a dentist. That is, without dentist supervision through a dental team concept, the independent mid-level provider, if economically able to practice in an underserved area at all, may only serve the patients as an intermediary of time and money lost, not of care gained.

Fails Minimum Educational Standards

Example independent mid-level provider concepts purport to include diagnostic, surgical, and irreversible restorative services without the direct supervision of a dentist. The American Dental Hygienists' Association's (ADHA) Draft Competencies referred to an excerpt of the American

Dental Education Association (ADEA) report, *Unleashing the Potential*, which reads, "In certain settings and situations, they substitute for the dentist where there is none available."⁷

Given that the unsupervised practice of an independent mid-level provider would mirror that of a dentist in the services provided, inclusive of diagnoses and irreversible procedures that presently are reserved for dentists, one must examine whether independent mid-level provider education and training would meet the minimal competencies required of the dentist in the performance of the same procedures.

The ADHA proposes an Advanced Dental Hygiene Practitioner (ADHP) master's degree curriculum to provide the hygienist with the competency required to provide diagnostic, therapeutic, preventive, and restorative services. However, notwithstanding that currently there is no Commission on Dental Accreditation (CODA)-approved ADHP master's degree program, dental school curricula designed to graduate DDS recipients are structured to meet only the *minimum* standards for competency in dentistry as set by the ADEA for CODA accreditation. Competency achieved through graduate dental education toward a DDS or DMD degree sets the floor, and not the ceiling, for the practice of clinical dentistry. **If these are the minimum standards, anything less could not render a practitioner competent to perform dentistry.**

Therefore, an ADHP master's degree curriculum, regardless of CODA accreditation, could not meet the minimum standards of competence to provide dentistry—especially diagnostic and irreversible dentistry—unless the ADHP master's degree curriculum were to adopt the prerequisites of dental school entry and meet or exceed the competencies achieved through dental school. That is, the ADHP master's degree candidate essentially would have to earn a dentist's degree to qualify as a practitioner of the aforementioned dental procedures.

Lesser Quality Care for Needier Patients

Since the educational framework proposed by the ADHA—and other organizations touting independent mid-level providers as solutions—is intended to fall short of comprehensive dental school curricula, the quality of care that an independent mid-level provider provides would fall short of the minimal competencies required of a dentist. One could argue that the benefit of competent care in dentistry already is a commodity only available to those who can afford it and that those who cannot afford it presently get nothing. However, the AGD strongly believes that those who cannot afford dental care, or perhaps are not aware of the importance of oral health, nonetheless **deserve the same quality and competence of care** as all.

Diagnosis and the performance of irreversible procedures by someone without a dentist's education compromise the safety of the patient. For the sake of patient safety, the AGD therefore urges that auxiliaries must be prohibited from engaging in the performance of irreversible procedures without direct dentist supervision⁸ and from diagnosing conditions of oral health regardless of supervision.

Notwithstanding the inherent injustice in providing lesser quality and po-

7 Weaver, R.G., Valachovic, R.W., Hanlon, L.L., Mintz, J.S., and Chmar, J.E. *Unleashing the Potential*. American Dental Education Association (ADEA). Available: http://www.adea.org/cepr/Documents/Unleashing_the_Potential.pdf.

8 If delivery of a local anesthetic is defined as an irreversible procedure, then said delivery may be considered an exception to the prohibition against practice without direct supervision if within the bounds of the laws and regulations of the respective jurisdiction. Additionally, jurisdictions may offer differing viewpoints on the scope of irreversible procedures and the allowance for non-dentists to perform them; however, whether these procedures, such as placement of a core, may be performed without the direct supervision of a dentist would require review and scrutiny on a case-by-case basis to ensure patient safety.

tentially unsafe care to more needy patients, one must also consider that disadvantaged populations often have neglected their dental health for years, thereby causing complications that are not as prevalent in better-advantaged communities. ***Without the benefit of dentist supervision or a dental team home, inappropriate care, possibly of unacceptable quality, may conceal or exacerbate underlying medical concerns and undermine dentistry and health care's growing effort to address dentistry as a doorway for the prevention of numerous systemic ailments.***

Dentistry Compared to Medicine

One might contend that independent mid-level providers in medicine, such as advanced nurse practitioners, have benefited the health care system. However, independent mid-level providers in dentistry and advanced nurse practitioners differ fundamentally in the models by which they practice, or intend to practice.

The dental concept and medical concept are vastly different. With its focus on addressing symptoms of illness rather than prevention of illness, the medical model is driven by a first diagnosis at the patient's "point of entry," and often a second or third diagnosis based upon the direction of referral. Therefore, in the medical model, the first diagnosis, regardless of by whom, merely opens the gateway to further evaluation and need not disturb subsequent diagnosis or the continuity of care.

On the other hand, dentistry has served its patients quite well through the prevention-based "dental team concept" rather than a "point of entry" concept. The dental team concept serves the function of dentistry and patients' access to care with its focus not merely on diagnosis of dental diseases, but rather on prevention and continuity of care through treatment. ***That is, in dentistry, the "point of entry" is the point of prevention and treatment—it is not just a segue to further diagnosis and possible intervention—thereby saving both time and cost.***

Further, treatment by a dental team varies within acceptable standards of care based upon the assessments, competencies, and preferred methodologies of the core dentist. Therefore, fragmentation of diagnosis or preliminary treatment shall not only hinder the dental team concept and dentistry's comprehensive view of treatment, but also it will hinder access to consistent quality care. That is, ***care shall be rendered discontinuous.***

Finally, it should be noted that dentistry faces significantly lesser insurance coverage for patients than medicine does. Nonetheless, insurance companies are likely to push patients to lower-cost care to the detriment of the patient. The AGD resists that effort and encourages competitive quality care to remain within the delivery of oral health care, inclusive of portability of any and all existing insurance coverage.

Therefore, while one can appreciate the medical model's efforts at an albeit inadequate solution to access to care with the adaptation of the nurse practitioner/physician assistant, a similar model likely would produce the opposite of the intended effect in dentistry; that is, it would *disrupt* continuity of care and access to quality of care for patient populations.

The Meaning of Quality Care

Defining the challenge in providing access to quality care is the first step in *addressing* the challenge. Access to quality care has two components: access and quality. Quality is a necessary component of access to care in order to ensure patient safety.

Accessibility without quality echoes the "something is better than nothing" approach to care. However, this approach serves only injustice and not the public need. A court of law does not provide an indigent defendant with a paralegal if he or she cannot afford an attorney. In dentistry,

this approach is naïve and can lead to tragedy. Inappropriate care, which may lead to unnecessary and dangerous complications, is not better than nothing—in fact, it can be enormously worse. Consequently, ***accessibility in dentistry is meaningless without the assurance of quality care.***

Therefore, ***the inadequately supervised independent mid-level provider holds the false goal of access to and utilization of care by compromising quality and safety while diverting valuable resources away from oral health literacy and expansion of quality care into underserved areas.***

V. Increasing Access and Utilization—A Comprehensive Patient-centered Solution

The profession of dentistry recognizes that the state of oral health cannot be materially advanced without addressing both access to and utilization of care. There are many different factors contributing to disparities in, lack of access to, and low utilization of oral health care services. Given the complexity of the issue, any solution will require a multi-faceted approach that strengthens the parts of the dental delivery system that are working and creates new opportunities to improve the oral health of the nation.

ORAL HEALTH LITERACY

Oral health literacy must be a cornerstone of improving utilization of care by underserved populations. Professional organizations such as the AGD actively promote publicly available, culturally relevant literature and other means to increase oral health literacy among underserved populations. However, true advances in oral health literacy must be driven by collaboration between professional organizations, community organizations, other private entities and governmental entities.⁹

The AGD believes health policymakers at the local, state and federal levels should continue their efforts to collaborate with the private sector to develop strategies for increasing access to and use of dental services and for decreasing oral health disparities and low oral health literacy. In May 2000, the groundbreaking release *Oral Health in America: A Report of the Surgeon General* recommended such public-private partnerships. Further, in the report, then-Surgeon General David Satcher, MD, PhD, referred to a "silent epidemic" of oral diseases among certain population groups in the United States. The following are just a few examples of activities that the AGD has undertaken in an effort to address the Surgeon General's Call to Action and to achieve HHS' *Healthy People 2010* oral health objectives:

1. The AGD created policy resolutions that if implemented would encourage adoption of policies that oppose soda pouring rights in schools because of the deleterious effect on oral health resulting from easy access to and increased consumption of soda and increase education on the importance of good nutrition and how good nutrition relates to good oral health.
2. The AGD's Public Relations Council regularly promotes topics and press releases on issues of interest to help mass media increase the consumer's awareness of oral health issues. For example, the council:
3. Developed a *Dentalnotes* story, "Dental Sealants—Is Your Child a Candidate?" which included information obtained from the CDC and

⁹ As a related component of oral health literacy, the AGD believes in the acceptance and execution of personal responsibility by patients. Being literate about one's oral health, especially in the context of receiving government-provided benefits, means, for instance, ensuring that one and one's children show up for scheduled appointments. The AGD also believes that a pecuniary interest in treatment facilitates personal responsibility. Commentators ranging from Adam Smith to Milton Friedman have clearly demonstrated that when a financial incentive exists, one is more likely to ensure optimal outcomes. In the context of both private insurance and government benefits, therefore, such a financial incentive would take the form of co-payment for treatment. This construct is even more important for lower socio-economic classes, which might not regularly be exposed to the profit motive.

- referenced the *Healthy People 2010* objectives related to sealants;
4. Built relationships with HHS, Office of Public Health and Science/ Office of the Surgeon General allowing for the council's input on a national public service announcement, which reached the top 10 media markets with a message about the link between dental health and overall health;
 5. Hosted an oral cancer screening event on July 17, 2003. More than 50 consumers were screened, 10 patients were encouraged to visit a dentist, and media coverage included *The Tennessean*, *Nashville City Paper*, *WTVF-TV*, *WLAC-AM*; and
 6. Hosted SmileLine events at AGD's annual meetings in order to answer patient inquiries about oral health. In 2003, more than 648 calls were answered, 50 questions were posted to SmileLine Online during the week of event, and 100 volunteers fielded a minimum of approximately eight calls per line per hour.
 7. The AGD has worked with the American Optometric Association (AOA) and the American Diabetes Association to inform patients about "above-the-neck" warning signs for diabetes, such as bad breath, bleeding gums, and blurred vision.
 8. The AGD's Legislative and Governmental Affairs (LGA) Council focuses its attention on promotion and implementation of the AGD's Memorandum of Understanding (MOU) with HHS. The purpose of the MOU is to provide a framework for cooperation between HHS and the AGD for promoting the *Healthy People 2010* oral health objectives with a focus on access to care, training of workforce, and the education of the public, the profession of general dentistry, and policymakers. This MOU, unique in organized dentistry, is directed to access to care through education of the public and policymakers about the links between oral health and overall health.

Incentives for Dentists to Practice in Underserved Areas

The AGD recognizes that ***the maldistribution of dentists is a significant challenge to access to care***. To successfully produce equitable distribution in areas now deemed underserved, ***incentives must be established to encourage dentists, especially those with GPR or AED training, who have attained the education and expertise to competently and comprehensively address the oral health needs of potentially compromised populations and to practice in underserved areas in conjunction with their dental teams***.

The AGD proposes ***the following steps—which are not to be construed as all-inclusive—as incentives to practice in underserved areas and to increase access to care:***

1. Extend the period during which student loans are forgiven to 10 years, without tax liabilities for the amount forgiven in any year;
2. Provide tax credits for establishing and operating a dental practice in an underserved area;¹⁰
3. Offer scholarships to dental students in exchange for committing to serve in an underserved area;
4. Increase funding of and statutory support for expanded loan repayment programs (LRPs);
5. Provide federal loan guarantees and/or grants for the purchase of dental equipment and materials;
6. Increase appropriations for funding an increase in the number of dentists serving in the National Health Service Corps and other federal programs, such as Indian Health Service (IHS) and programs

10 ***"The Maine Dental Association's own bill, called 'An Act to Increase Access to Dental Care,' has become law***. Starting next year, dentists will be eligible to receive up to \$15,000 in income tax credit annually for up to five years as long as they practice in underserved areas. The law currently limits participation in the program to five dentists, but the legislature will review its effectiveness in two years and may then amend it to increase the number of allowed participants." American Dental Association (ADA) Update, June 10, 2008. Available: www.ada.org.

7. Actively recruit applicants for dental schools from underserved areas; and
8. Assure funding for Title VII GPR and pediatric dentistry residencies.

Specifically, the GPR and pediatric dentistry residency programs funded by the appropriations bill for the HHS, and education as part of the Health Professions Program under Title VII of the Public Health Service Act, are proven, cost-effective primary care residency programs. They are a small investment with clear benefits.

During the 20-year history of the Title VII support for general dentistry training, 59 new dental residency programs and 560 new positions were created. Approximately 305 of the dentistry graduates from these programs established practices and spent 50 percent or more of their time in health professional shortage areas or settings providing care to underserved communities.

THE BENEFITS OF GPR PROGRAMS INCLUDE:

More primary care providers: GPR programs provide dental graduates with broad skills and clinical experience, allowing them to rely less on specialists. Residents are trained to provide dental care to patients requiring specialized or complex care, such as individuals with intellectual and developmental disabilities, the elderly, high-risk medical patients and patients with HIV/AIDS. Eighty-seven percent of the graduates of GPR programs remain primary care providers after graduation.

Better distribution of care: General practice residency programs improve distribution into underserved areas. A 2001 Health Resources and Services Administration (HRSA)-funded study found that postdoctoral general dentistry training programs, which typically either are dental school- or hospital-based, generally serve as safety net providers to underserved populations.

The GPR program is a model for the type of program that the government should support during times of scarce resources because it is cost-effective, it targets and provides care to underserved populations and it trains practitioners to become comprehensive general dentists, thus keeping more future health care costs to a minimum due to its primary care emphasis.

Legislative and Community Initiatives for Increasing Access to and Utilization of Care

It should be noted that the majority of the areas that the federal government considers underserved are determined by the low economics of the region. This also should bring an understanding that the care in the underserved areas where these patients live is funded substantially by government-funded programs (i.e., Medicaid). Historically, ***when states have raised the Medicaid reimbursement rates, the number of provider dentists have increased, which, in turn, has led to a direct increase in patients in underserved areas receiving care.***¹¹

11 "Over the past decade, Medicaid and Head Start programs have sought to enhance the enrollees' access to early, ongoing, appropriate, comprehensive dental services. However, progress...[has been] hindered by long-standing barriers that discourage dentists' participation in Medicaid. Included among the most widely identified barriers are inadequate program financing and reimbursement." *National Oral Health Policy Center, Technical Issue Brief*, October, 2007. When Medicaid has been expanded and reimbursement rates raised, utilization and care have increased. For example, "in 2000, Michigan's Medicaid dental program initiated Healthy Kids Dental, or HKD, a demonstration program offering dental coverage to Medicaid-enrolled children in selected counties. The program was administered through a private dental carrier at private reimbursement levels... Under HKD, dental care utilization increased 31.4 percent overall and 39 percent among

Specifically, the **following are some of the steps that the AGD recommends to increase both access to care and utilization of care:**

1. Take steps to facilitate effective compliance with government-funded dental care programs to achieve optimum oral health outcomes for indigent populations:
 - a. Raise Medicaid fees to at least the 75th percentile of dentists' actual fees;
 - b. Eliminate extraneous paperwork;
 - c. Facilitate e-filing;
 - d. Simplify Medicaid rules;
 - e. Mandate prompt reimbursement;
 - f. Educate Medicaid officials regarding the unique nature of dentistry;
 - g. Provide block federal grants to states for innovative programs;
 - h. Require mandatory annual dental examinations for children entering school (analogous to immunizations) to determine their oral health status;
 - i. Encourage culturally competent education of patients in proper oral hygiene and the importance of keeping scheduled appointments;
 - j. Utilize case management to ensure that the patients are brought to the dental office; and
 - k. Increase general dentists' understanding of the benefits of treating indigent populations.
2. Establish alternative oral health care delivery service units;
3. Provide exams for one-year-old children as part of the recommendations for new mothers to facilitate early screening;
4. Provide oral health care, education, and preventive programs in schools;
5. Arrange for transportation to and from care centers; and
6. Solicit volunteer participation from the private sector to staff the centers.
7. Encourage private organizations, such as Donated Dental Services (DDS), fraternal organizations, and religious groups to establish and provide service;
8. Provide mobile and portable dental units to service the underserved and indigent of all age groups;
9. Identify educational resources for dentists on how to provide care to pediatric and special needs patients and increase AGD dentist participation;
10. Provide information to dentists and their staffs on cultural diversity issues which will help them reduce or eliminate barriers to clear communication and enhance understanding of treatment and treatment options;
11. Pursue development of a comprehensive oral health education component for public schools' health curricula in addition to providing editorial and consultative services to primary and secondary school textbook publishers;
12. Increase the supply of dental assistants and dental hygienists to engage in prevention efforts within the dental team;
13. Expand the role of auxiliaries within the dental team that includes a dentist or is under the direct supervision of a dentist;
14. Eliminate barriers and expand the role that retired dentists can play in providing service to indigent populations;
15. Strengthen alliances with the ADEA and other professional organizations, such as the Association of State and Territorial Health Officials

(ASTHO), the Association of State and Territorial Dental Directors (ASTDD), the National Association of Local Boards of Health (NALBOH) and National Association of County & City Health Officials (NACCHO);

16. Lobby for and support efforts at building the public health infrastructure by using and leveraging funds that are available for uses other than oral health; and
17. Increase funding for fluoride monitoring and surveillance programs as well as for the development and promotion of new fluoride infrastructure.

An important distinction must be made between supporting the advancement of auxiliaries within the dental team or under dentist supervision and opposing the independent practice of independent mid-level providers. Education has been the hallmark of the AGD since its inception. **The education of auxiliaries within the dental team concept will advance the interests of patient health.** On the other hand, as explained above, the practice of independent mid-level providers impedes the access to and utilization of oral health care services.

Rather, **the AGD strongly supports those individuals who reside in federally designated underserved areas, especially if they possess cultural competency, and who are interested in performing irreversible oral health procedures, to matriculate in dental school.** The AGD stands ready to lobby both Congress and state legislatures to ensure that there are appropriate funding mechanisms for such educational endeavors. The AGD further warrants that, based on its long history of supporting continuing education and its support of mentoring programs, it will make every effort for established dentists to take all necessary steps to ensure the professional development of these new dentists.

VI. Conclusion

The AGD believes the role of the general dentist, in conjunction with the dental team, is of paramount importance in improving both access to and utilization of oral health care services. The AGD is willing and able to work with other communities of interest to address and solve disparities in access to and utilization of care across the nation. We should work together to make sure that all Americans receive the very best comprehensive dental care that will give them optimal dental health and overall health.

During this process, we must maintain our focus on the patient and maintain awareness that dentistry works best as a preventive system. As noted in *Oral Health in America: A Report of the Surgeon General*, "Oral diseases are progressive and cumulative and become more complex over time." Fortunately, "Most common oral diseases can be prevented."

children continuously enrolled for 12 months, compared with the previous year under Medicaid. Dentists' participation increased substantially, and the distance traveled by patients for appointments was cut in half." Michigan Medicaid's Healthy Kids Dental Program: An Assessment of the First 12 Months (2003). *Journal of the American Dental Association (JADA)*, Vol. 134, 1509-15 (November, 2003). Michigan is one of many other states where similar results have been noted.

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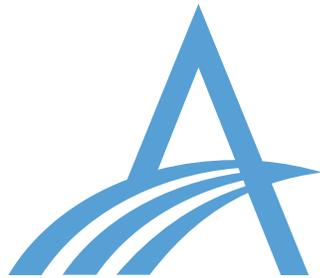
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BARRIERS AND SOLUTIONS TO ACCESSING CARE

“to serve and protect the oral health of the public”



Barriers and Solutions to Accessing Care

INTRODUCTION

In 2000, the Office of the Surgeon General (OSG) identified the condition of oral health in the United States as an epidemic, noting that illnesses related to oral health resulted in approximately 6.1 million days of bed disability, 12.7 million days of restricted activity, and 20.5 million lost workdays each year.¹

Since then, numerous organizations, public and private, have dedicated countless hours and dollars to propose solutions to improve “access to care.” However, more than a decade following the OSG’s warning, very little has been accomplished to improve the oral health of the public.

The reasons for this lack of progress are many, including federal and state budgetary constraints, wasteful expenditures on unproven programs, misidentification of the problem as a shortage or unwillingness of providers to provide care, and failure to convince the public to adopt positive oral health habits.

The focus of this paper is to identify the underlying barriers that have held us back from bettering the state of oral health over the last 12 years, and also provide us with proven solutions for improving the public’s overall oral health in the United States.

Future publications of the Academy of General Dentistry (AGD) shall further explore each oral health barrier, identifying what has and has not worked in areas across the nation, and how we may apply those lessons to overcome barriers in other areas.

BARRIERS AND SOLUTIONS

“Access” is a term used for a broad set of concerns that center on the degree to which individuals and groups are able to obtain needed services from the health care system. Often, because of difficulties in defining and measuring the term, legislatures equate access with insurance coverage and with having enough doctors and hospitals within a given area.

However, having insurance or having health care providers located within the immediate vicinity does not guarantee individuals will receive the treatment and services they require. Conversely, when other barriers are addressed, both insured and uninsured residents of federally-sanctioned shortage areas can find and receive care. Therefore, while access has been used by some to refer to coverage and proximity, the extent to which a population “gains access” to health care depends, instead, upon financial, organizational, and social or cultural barriers that may limit utilization.

The AGD believes that addressing the following key barriers will allow the U.S. public to properly gain and utilize available oral health care:

1. Oral health literacy
2. Psychological factors
 - a. Turning literacy into healthy behaviors (Patient activation)
 - b. Treatment mentality vs. prevention mentality
 - c. Social and cultural misperceptions
3. Financial factors
 - a. Economics of sustainable care delivery
 - b. Provider distribution
4. Patients with special needs

ORAL HEALTH LITERACY

According to Title V, Subtitle A, of the Patient Protection and Affordable Care Act (2010), “The term ‘health literacy’ means the degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health decisions.”²

The American Dental Association Health Literacy in Dentistry Action Plan, 2010–2015 further indicates that, “In the U.S., limited literacy skills are a stronger predictor of an individual’s health status than age, income, employment status, education level, and racial or ethnic group. Limited health literacy is estimated to cost the U.S. between \$100 and \$200 billion each year.”³

Increased oral health literacy provides a first step toward enabling patients to see value and ask for services, and will inspire communities to consider positive oral health a priority they should work toward achieving.

Oral health literacy efforts have paid dividends in numerous states across the nation. The AGD calls for collaboration from all oral health stakeholders to help in:

- Developing a comprehensive oral health education component for public schools’ health curriculums, in addition to providing editorial and consultative services to primary and secondary school textbook publishers;
- Providing oral health exams for 1-year-olds to help facilitate early screenings and implement oral health recommendations for children and their mothers;

1. U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2000. NIH publication 00-4713. Available from: URL: www.surgeongeneral.gov/library/oralhealth

2. Patient Protection and Affordable Care Act, PL 111-148, March 23, 2010, 124 Stat 119. See also Tetine Sentell. Implications For Reform: Survey of California Adults Suggests Low Health Literacy Predicts Likelihood of Being Uninsured. *Health Affairs*, 31, no.5 (2012):1039

3. American Dental Association (ADA) Council on Access, Prevention and Interprofessional Relations. American Dental Association Health Literacy in Dentistry Action Plan, 2010–2015. 2009: 1. (The ADA further states that limited health literacy is “a potential barrier to effective prevention, diagnosis and treatment of oral disease,” and that “clear, accurate and effective communication is an essential skill for effective dental practice.”)

- Equipping teachers at various levels with creative educational tools, including educational videos, puzzles, word searches, and experiments that show children the value of their teeth and how to care for them;
- Training daycare providers and school nurses on the importance of oral health, including nutrition's role in maintaining healthy teeth;
- Providing dental information on the use of bottled water, fluoride, fluoride varnishes, and appropriate diets to pediatricians;
- Offering multi-factorial interventions and educational programs to parents of young children, including through public media and information provided at hospitals and other health care points of care.⁴

PSYCHOLOGICAL FACTORS

Patient activation, turning literacy into healthy behaviors

When one truly understands the importance of oral health, he or she acts upon it, and action in turn becomes engrained as value. Patient activation encapsulates, "how confident, skillful, and knowledgeable they are about taking an active role in improving their health and health care."⁵ Patient activation is the unspoken solution to improving oral health, a solution that is readily available.

Unfortunately, studies have shown that educating patients about the importance of proper oral health care isn't enough to lead to patient activation and positive patient outcomes.⁶ Education must be coupled with health promotion to ultimately result in patients' realizing and acting upon their need for preventive care, both through self-care at home and through regular visits to their dentist—a dental home.

"Health promotion supports individuals in translating their health knowledge into positive behaviours and lifestyles. Health promotion activities should be directed at a wide variety of areas likely to impact on health, e.g. social, economic, and structural environments, as well as the policies of public and local institutions. The rationale is to increase the community's day-to-day capacity and ability to follow a healthy lifestyle... [Health promotion] interventions have included the tailoring of information to meet the needs of specific groups, active involvement by participants, direct contact from services and active learning techniques in addition to dental health education."⁷ This often requires a multi-factorial approach.

Treatment mentality vs. prevention mentality

"A study of decay-related ER [emergency room] visits in 2006 found that treating about 330,000 cases cost nearly \$110 million. States are saddled with some of these expenses through Medicaid and other public programs."⁸

Additionally, "a study in Washington State revealed that a trip to the ER was the first 'dental visit' for one in four children overall, and for roughly half the children younger than 3 and a half years."⁹

The success of our efforts for oral health improvement should be measured by the outcome goal of no disease. The U.S., like many other countries, including New Zealand, has a fixation on treatment as the route to quality oral health. However, in contrast, some countries like Denmark—a nation whose dental health outcomes are much more positive than those of New Zealand and even the United States—succeed due to their focus on prevention at a very early age, rather than the notion that fillings, extractions, and root canals are the answer. By focusing on the preventable nature of dental disease, Denmark has greatly reduced the need for treatment interventions, whereas in New Zealand and elsewhere, the use of increased treatment mainly by therapists has not caused a decrease in dental caries.¹⁰

The issue of emergency room visits is a symptom of our treatment mentality when it comes to health care, and prevention is the solution. We must stop resorting to emergency rooms as a place for oral health care, and promote preventive oral health care at home and in the dental home.

In order to do this, patients need to be connected to a dental home and have a sustainable relationship with a fully-trained dentist. Solutions targeted to move dentistry away from expensive emergency room care and back to the dental home include:

- Developing and funding patient navigators to work within communities and ensure that patients keep preventive appointments;
- Minimizing emergency room visits and return rates.

Social and cultural misperceptions

"Oral health knowledge and practices differ by ethnicity and culture. Groups vary in beliefs about the usefulness of treating the primary teeth;

4. NHS Quality Improvement Scotland. Prevention and management of dental decay in the pre-school child: A National Clinical Guideline. *Scottish Intercollegiate Guidelines Network (SIGN)*. 2005: 20. (This guideline further states:

The oral health of young children should be promoted through multiple interventions and multisessional health promotion programmes for parents.

- Oral health promotion programmes to reduce the risk of early childhood caries should be available for parents during pregnancy and continued postnatally.
- Oral health promotion programmes for young children should be initiated before the age of three years

Oral health promotion programmes should address environmental, public and social policy changes in order to support behaviour change.)

5. Peter J. Cunningham, Judith Hibbard and Claire B. Gibbons. Raising Low 'Patient Activation' Rates Among Hispanic Immigrants May Equal Expanded Coverage In Reducing Access Disparities. *Health Affairs*, 30, no.10 (2011):1888

6. NHS Quality Improvement Scotland, op.cit., p. 19. ("A review of public health education interventions found that studies aiming to increase knowledge were successful, but the effect of information acquisition on behaviour

was uncertain. It concluded that health education interventions alone are insufficient to change behaviour but can be effective when combined with environmental or legislative changes"). See also, Susan A. Fisher-Owens, Judith C. Barker, Sally Adams, Lisa H. Chung, Stuart A. Gansky, Susan Hyde and Jane A. Weintraub. Giving Policy Some Teeth: Routes to Reducing Disparities in Oral Health. *Health Affairs*, 27, no.2 (2008):407. ("In the latest Research!America poll, 97 percent responded that oral health was somewhat or very important to overall health, yet oral health is a top unmet need for many")

7. NHS Quality Improvement Scotland, op.cit., p. 19

8. The Pew Center on the States. A Costly Dental Destination: Hospital Care Means States Pay Dearly. 2012: 1. Available at: www.pewstates.org/projects/childrens-dental-campaign-328060 (Referring to the findings of R. Nalliah, V. Allareddy, S. Elangovan, N. Karimbux, and V. Allareddy, "Hospital Based Emergency Department Visits Attributed to Dental Caries in the United States in 2006," *Journal of Evidence Based Dental Practice* (2010), Vol. 10, 212-222, [www.jebdp.com/article/S1532-3382\(10\)00183-1/abstract](http://www.jebdp.com/article/S1532-3382(10)00183-1/abstract).)

9. *ibid.*, p. 3.

10. American Academy of Pediatric Dentistry (AAPD) Council on Clinical Affairs. Policy on Workforce Issues and Delivery of Oral Health Care Services in a Dental Home. *AAPD Oral Health Policies, Reference Manual*. Vol. 33. No. 6. 2011: 28 ("New Zealand, known for utilizing dental therapists since the 1920's and frequently referenced as a workforce model for consideration in the US, recently completed its first nationwide oral health status survey in over 20 years. Dental care is available at no cost for children up to 18, with most public primary schools having a dental clinic and many regions operating mobile clinics. Overall, 1 in 2 children in New Zealand aged 2-17 years was caries-free. The caries rate for 5 year olds and 8 year olds in 2009 was 44.4% and 47.9% respectively. These caries rates, which are higher than the US, United Kingdom, and Australia, help refute a presumption that utilization of non-dentist providers will overcome the disparities.").

See also, Gillies A. NZ children's dental health still among worst. *The New Zealand Herald*. March 6, 2011. Available at: www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10710408. Accessed March 14, 2011.

See also, Ministry of Health. Our Oral Health: Key findings of the 2009 New Zealand Oral Health Survey. Wellington: Ministry of Health. 2010. Available at: www.moh.govt.nz. Accessed March 14, 2011.

caries etiologies; the meaning of oral pain, dental discolorations, or loss; home remedies; dental hygiene and preventive efficacy; and trusted dental information sources.”¹¹

The U.S. Native American population reflects this stark contrast in social and cultural realities. According to the South Dakota Dental Association, Native American children, between 2 and 5 years old, are three times more likely to have untreated decay than children of the same age group in the general U.S. population, 68 percent and 19 percent, respectively.¹²

However, these social and cultural misperceptions may be overcome by:

- Providing information to dentists and their dental teams on cultural diversity concerns, which will help dental professionals reduce or eliminate communication barriers and help enhance patients’ understanding of treatment and treatment options;
- Working with community leaders to break down cultural barriers;
- Providing oral health information in multiple languages through multiple community channels;¹³
- Working with Indian Health Services (IHS) and community organizations such as COPE.¹⁴

FINANCIAL FACTORS

Economics of sustainable care delivery

According to Timothy Oh, DMD, “When we talk about raising the [Medicaid] reimbursement, we really are looking at being able to reimburse small businesses and dentists to make the care that they provide sustainable.”¹⁵ State efforts to make care for all persons economically feasible have been proven to be effective.¹⁶

Solutions for making care economically feasible for vulnerable populations include:

- Extending the period over which student loans are forgiven for dental school students, to 10 years without tax liabilities for the amount forgiven in any year;
- Providing tax credits to dentists who establish and operate dental practices that serves vulnerable populations;
- Offering scholarships to dental students in exchange for commitments to serve vulnerable populations;

- Providing senior dental students education through the provision of care in outreach community dental facilities supervised by dental faculty;¹⁷
- Increasing funding of and statutory support for expanded loan repayment programs (LRPs) for dental school graduates;
- Providing federal loan guarantees and/or grants for the establishment and equipping of dental clinics in underserved or financially challenged areas;
- Increasing appropriations funding for the U.S. Department of Health and Human Services (HHS) loan repayment programs for dental school graduates and for the National Health Service Corps, Indian Health Services, and other federal programs, which would allow the creation of more dentist positions for programs that serve disadvantaged populations;
- Developing dental clinics within hospitals to treat dental emergencies that are too complicated or systemically compromised to treat in community clinics;
- Funding for dentists who provide oral health care within hospital dental clinics;
- Taking the following steps to facilitate effective compliance with government-funded dental care programs, helping achieve optimum oral health outcomes for indigent populations:

- Raising Medicaid fees to at least the 75th percentile of dentists’ actual fees
- Eliminating extraneous paperwork
- Facilitating e-filing
- Simplifying Medicaid rules
- Mandating prompt reimbursement
- Educating Medicaid officials on the unique nature of dentistry
- Providing block federal grants to states for innovative oral health programs
- Requiring mandatory annual dental examinations for children entering school (analogous to immunizations) to determine their oral health status
- Educating patients in a culturally sensitive manner about the importance of proper oral hygiene and routine oral health appointments

11. Susan A. Fisher-Owens, Judith C. Barker, Sally Adams, Lisa H. Chung, Stuart A. Gansky, Susan Hyde and Jane A. Weintraub. Giving Policy Some Teeth: Routes to Reducing Disparities in Oral Health. *Health Affairs*, 27, no.2 (2008):407

12. Albino, J. E. N. and Orlando, V. A. (2010), Promising directions for caries prevention with American Indian and Alaska Native children. *International Dental Journal*, 60: 216–222. doi: 10.1922/IDJ_2566Albino07

13. Tetine Sentell. Implications for Reform: Survey of California Adults Suggests Low Health Literacy Predicts Likelihood of Being Uninsured. *Health Affairs*, 31, no.5 (2012):1039-1044 (“It is also worth noting the importance of having outreach and materials for both Medicaid and the insurance exchanges in multiple languages, given that 60.4 percent of the uninsured with low health literacy had limited English proficiency, as did 26.6 percent of the uninsured with adequate health literacy.”)

14. Brigham and Women’s Hospital (BWH) Bulletin. Health Workers Help Navajo Patients Cope. 2012. Available at: www.brighamandwomens.org/About_BWH/publicaffairs/news/publications/

DisplayBulletin.aspx?articleid=5533&issueDate=3/30/2012%2012:00:00%20AM. Accessed May 25, 2012. (“The Community Outreach and Patient Empowerment (COPE) Program is a formal collaboration between the Navajo Nation Community Health Representative Program, the Gallup, Shiprock, Fort Defiance and Chinle Service Units of the Indian Health Service, and BWH’s Division of Global Health Equity.”)

15. Dental Therapists / Maine’s Maple Sugar Industry [transcript]. The Maine Public Broadcasting Network. March 22, 2012. (Dr. Oh stated, “On average the overhead for providing dental care is quite high; it’s about 65% that’s on a normal fee but [Medicaid] reimburses dentists at approximately 25% [or similar % in your state] of the usual and customary fees. So if it costs 65% percent to just cover your overhead, that fraction of a reimbursement you get is often a loss. There are many offices that would take [Medicaid] if the reimbursement is brought up to a sustainable level and that would be more fair to the patients and to the providers.”)

16. *ibid.* (Dr. Oh further stated, “[In Connecticut, in 2007,] there were only 150 dentists who took their Medicaid program to provide dental benefits. The Connecticut legislature realized this and said we have to find a way to make this care sustainable. So, in 2008, they passed legislation to increase the reimbursement for their Medicaid dental procedures. Within a couple of years they went from 150 providers who were accepting Medicaid children to over 1,000. This wasn’t dentists who were worried about making money; this wasn’t about making the largest possible profit. This was just making sure that the care was reimbursed so that the dentist’s office would stay open and they could keep taking the patients.”)

17. Commission on Dental Accreditation. Accreditation Standards for Dental Education Programs. 2012: 19. Available at: www.ada.org/sections/educationAndCareers/pdfs/predoc_2013.pdf. Accessed June 6, 2012. (Standard 1-9 requires that “the dental school must show evidence of interaction with other components of the higher education, health care education and/or health care delivery systems,‘ will help guide more of our schools in this direction.”)

- Utilizing case management to ensure that patients are brought to the dental office
- Increasing the general dentist’s understanding of the benefits of treating indigent populations;
- Encouraging funding from organizations that serve the public, including the W.K. Kellogg Foundation, Pew Charitable Trusts, DentaQuest, and the Robert Wood Johnson Foundation, to support the above solutions.
- Encouraging private organizations, such as Donated Dental Services (DDS), fraternal organizations, and religious groups to establish and provide services;
- Providing mobile and portable dental units to serve varying age groups in underserved areas or places with indigent populations.

PATIENTS WITH SPECIAL NEEDS

Patients with special needs include patients with disabilities, elderly patients, and those with medical conditions or co-morbidities that require additional care. Vulnerable populations often include a high proportion of patients with special needs, reminding us of the importance of ensuring that these patients receive high-quality care by educated and licensed dentists. Solutions to ensure the provision of high-quality care for these deserving populations include:

- Assuring funding for Title VII general practice residency (GPR), advanced education in general dentistry (AEGD), and pediatric dentistry residencies;
- Identifying educational resources for dentists on how to provide care to pediatric and special needs patients.

Provider distribution

The AGD recognizes that the distribution of dentists is a consideration to access to care in certain geographic locations. However, the AGD disagrees with Americans being labeled as “underserved” strictly by the ratio of dentists to number of persons in their localities, without regards to practice capacity, volunteer programs, and other important factors.

Further, as evidenced by the vast number of patients who routinely travel to receive care at volunteer clinic events, such as those held by the Missions of Mercy (MOM), it is clear that other financial barriers present a far greater challenge than provider location.

Nonetheless, where distribution of dentists can be addressed with a limited expenditure of resource, it should be addressed. To successfully produce equitable distribution of care in areas now deemed underserved, incentives must be established to encourage dentists who have attained the education and expertise—particularly general practice residency (GPR) or advanced education in general dentistry (AEGD) training—to competently and comprehensively address the oral health needs of potentially compromised populations and to practice in underserved areas in conjunction with their dental teams. Many of these incentives have been presented above as solutions. However, numerous economically conservative solutions are also readily available to help connect the underserved patient with a dentist.

Solutions that bridge the location gap include:

- Actively recruiting dental school applicants who are from underserved areas;
- Establishing alternative oral health care delivery service units, including arranging for transportation to and from care centers and soliciting volunteer participation from the private sector;

CONCLUSION

The AGD believes that the role of the general dentist, in conjunction with the dental team, is of paramount importance to improving both access to and utilization of oral health care services. Equally important is the need for every member of the public to understand the importance of his or her own oral health and to transfer that understanding into action.

The AGD is willing and capable of working with other communities of interest to address and solve disparities in access to and utilization of care across the nation. We should work together to make sure that all Americans receive the very best comprehensive dental care, which will ultimately lead to optimal dental and overall health.

During this process, we must maintain our focus on the patient and maintain awareness that dentistry works best as a preventive system. As the OSG noted more than a decade ago in “Oral Health in America: A Report of the Surgeon General,” “Oral diseases are progressive and cumulative and become more complex over time.” But as we all know, many of these common oral diseases are easily prevented.

ACKNOWLEDGMENTS

The Academy of General Dentistry (AGD) Barriers and Solutions to Accessing Care was developed by the AGD Board appointed White Paper Task Force in collaboration with the Dental Practice (DP) and Legislative & Governmental Affairs (LGA) Councils, the Division Coordinator to the DP and LGA Councils, the Executive Committee, and AGD Staff. The paper could not have been completed successfully without the dedication, persistence, expertise, and tireless efforts of these individuals, and therefore, they are recognized by name as follows:

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Academy of General Dentistry, July 2012



Resolution in Support of Oral Health Curriculum

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Resolution in Support of Oral Health Curriculum

WHEREAS, oral health is distinct from other aspects of health care in that oral health predominantly relates to two diseases—caries and periodontal disease—both of which are largely preventable; and

WHEREAS, unlike in medicine, emergency room visits for oral health should be entirely avoidable; and

WHEREAS, an analysis of emergency room visits in Florida from 2008 to 2010 for preventable dental conditions found the number of patients seeking emergency room dental care increased by 10,000 (9.2 percent), with charges increasing by more than \$21 million (32.9 percent); and

WHEREAS, more than half of the increase in charges over that period—\$12.9 million—was attributable to Medicaid and Medicaid Managed Care; and

WHEREAS, the same analysis found that publicly funded emergency room dental care for children doubled from 2008-2010; and

WHEREAS, available studies suggest a statistically significant association between health illiteracy and increased costs in Medicaid patients in emergency rooms; and

WHEREAS, the continued prevalence of preventable oral health issues places undue strain on both private and public resources.

NOW, THEREFORE BE IT RESOLVED, that {insert state legislature}, recognizing the importance of achieving and maintaining good oral health, supports the adoption of an oral health standards curriculum in public schools.

BE IT FURTHER RESOLVED, that {insert state legislature} encourages the voluntary assistance of dental health professionals and organizations to assist in the development and delivery of such curriculum.

Approved by the ALEC Board of Directors January 9, 2014.

Keyword Tags: [2013 SNPS](#), [Health and Human Services Task Force](#)

Task Forces

[Health and Human Services](#)

MISSISSIPPI LEGISLATURE

2013 Regular Session

To: Public Health and Human Services

By: Representatives Mims, DeBar

House Bill 776

(As Sent to Governor)

AN ACT TO CREATE NEW SECTIONS 37-146-1, 37-146-3, 37-146-5, 37-146-7, 37-146-9, 37-146-11, 37-146-13, 37-146-17, 37-146-19 AND 37-146-21, MISSISSIPPI CODE OF 1972, TO ENACT THE MISSISSIPPI RURAL DENTISTS SCHOLARSHIP PROGRAM FOR THE PURPOSE OF IDENTIFYING QUALIFIED UNIVERSITY AND COLLEGE STUDENTS FROM RURAL AREAS OF THE STATE FOR DENTAL SCHOOL MATRICULATION; TO ESTABLISH THE MISSISSIPPI RURAL DENTISTS SCHOLARSHIP COMMISSION TO PROMULGATE RULES AND REGULATIONS FOR PARTICIPATION IN THE SCHOLARSHIP PROGRAM; TO PRESCRIBE APPLICANT QUALIFICATIONS AND PROVIDE A MAXIMUM NUMBER OF NEW ADMISSIONS PER YEAR; TO PROVIDE STANDARDS FOR PARTICIPATION IN THE PROGRAM; TO PROVIDE THAT THE STUDENT IS OBLIGATED FOR ONE YEAR OF PRACTICE AS A DENTIST IN A RURAL AREA FOR EVERY YEAR OF FINANCIAL ASSISTANCE; TO DEFINE THE LIMITATION OF PROGRAM ADMINISTRATIVE AUTHORITY; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. The following provision shall be codified as Section 37-146-1, Mississippi Code of 1972:

37-146-1. **Mississippi Rural Dentists Program established.** There is established the Mississippi Rural Dentists Scholarship Program for the purpose of identifying and recruiting qualified university and college students from rural areas of the state for dental school matriculation. The program shall consist of three (3) distinct phases through which participants will progress, including:

- (a) Undergraduate pre-dental education;
- (b) Dental school and residency; and
- (c) Initial entry into dental practice in a rural or underserved area of the State of Mississippi.

SECTION 2. The following provision shall be codified as Section 37-146-3, Mississippi Code of 1972:

37-146-3. **Mississippi Rural Dentists Scholarship Commission; compensation; program funding.** (1) The Mississippi Rural Dentists Scholarship Program shall be administered by a commission to be known as the "Mississippi Rural Dentists Scholarship Commission." The commission shall be directed by a board composed of the following members:

(a) Two (2) dentists appointed by and from the membership of the Mississippi Dental Association, the term of which shall be three (3) years and who may be reappointed for one (1) additional term;

(b) One (1) dentist appointed by and from the membership of each of the following organizations, the term of which shall be three (3) years and who may be reappointed for one (1) additional term:

- (i) Mississippi Dental Society;
- (ii) Mississippi Academy of General Dentistry; and
- (iii) Mississippi Chapter, American Academy of Pediatric Dentistry;

(c) Two (2) designees of the Dean of the University of Mississippi School of Dentistry whose terms are at the discretion of the dean, at least one (1) of whom is a member of the University of Mississippi School of Dentistry Admissions Committee; and

(d) Two (2) dental students, one (1) of whom shall be selected yearly through a process developed by the Dean of the School of Dentistry in consultation with the chairs of the various departments.

(2) The pre-professional advisors from the accredited four-year colleges and universities in the State of Mississippi shall comprise an advisory committee to the commission in the administration of the Mississippi Rural Dentists Scholarship Program.

(3) Vacancies on the commission must be filled in a manner consistent with the original appointments.

(4) All appointments to the commission must be made no later than September 1, 2013. After the members are appointed, the Program Director of the Mississippi Rural Dentists Scholarship Program shall set a date for the organizational meeting that is mutually acceptable to the majority of the commission members. The organizational meeting shall be for the purposes of organizing the commission and establishing rules for transacting its business. A majority of the members of the commission shall constitute a quorum at all commission meetings. An affirmative vote of a majority of the members present and

voting shall be required in the adoption of rules, reports and in any other actions taken by the commission. At the organizational meeting, the commission shall elect a chair and vice chair from the members appointed according to paragraphs (a) through (d) of subsection (1). The chair shall serve for a term of two (2) years, upon the expiration of which, the vice chair shall assume the office of chair.

(5) After the organizational meeting, the commission shall hold no less than two (2) meetings annually.

(6) The commission may form an executive committee for the purpose of transacting business that must be conducted before the next regularly scheduled meeting of the commission. All actions taken by the executive committee must be ratified by the commission at its next regularly scheduled meeting.

(7) Members of the commission shall serve without compensation but may be reimbursed, subject to the availability of funding, for mileage and actual and necessary expenses incurred in attending meetings of the commission, as provided in Section 25-3-41.

(8) Funding for the establishment and continued operation of the program and commission shall be appropriated out of any money in the State General Fund not already appropriated to the University of Mississippi Medical Center.

SECTION 3. The following provision shall be codified as Section 37-146-5, Mississippi Code of 1972:

37-146-5. **Powers and duties of the commission.** The Mississippi Rural Dentists Scholarship Commission shall have the following powers and duties:

(a) Developing the administrative policy for the commission and the Mississippi Rural Dentists Scholarship Program;

(b) Promulgating rules and regulations, with the advice and consent of the University of Mississippi Medical Center, pertaining to the implementation and operation of the Rural Dentists Scholarship Program;

(c) Developing and implementing strategies and activities for the identification and recruitment of students and for marketing the program and for the implementation of the program. In developing these strategies, the board shall seek the input of various organizations and entities.

(d) Establishing a budget, with the advice and consent of the University of Mississippi Medical Center, to support the activities of the program and periodically reviewing and if appropriate, revising, the scholarship and other stipends offered through the program;

(e) Advising the University of Mississippi Medical Center regarding hiring appropriate staff necessary to work in conjunction with the Executive

Director of the Mississippi Rural Physicians Scholarship Program.

(f) Reviewing participants' progress in the program and mentoring students and dentists participating in the program;

(g) The commission shall have the authority through use of generally applicable definitions, to designate an area of the state as underserved or rural. The method by which these designations shall be made shall be contained in rules and regulations promulgated by the commission.

SECTION 4. The following provision shall be codified as Section 37-146-7, Mississippi Code of 1972:

37-146-7. Identification and recruitment of undergraduate participants; designation of underserved or rural area; applicant qualifications; maximum number of new admissions per year. (1) The commission shall develop and implement policies and procedures designed to recruit, identify and enroll undergraduate students who demonstrate necessary interest, commitment, aptitude and academic achievement to pursue careers as dentists in rural or dentally underserved areas of Mississippi, and to develop and implement the programs designed to foster successful entry of participants into dental school, completion of dental school, and establishment and maintenance of a career in dentistry in a rural or underserved area of Mississippi.

(2) The commission shall have the authority through use of generally applicable definitions, to designate an area of the state as underserved or rural.

(3) The commission, in conjunction with the University of Mississippi Medical Center, shall have the authority to provide students selected for scholarship funding with faculty mentors and other programs designed to enhance the students' likelihood of admission to the dental school. The commission and the University of Mississippi Medical Center will develop coursework that will help provide scholarship students with the skills necessary for sustained and successful dental practice in rural Mississippi.

(4) Each applicant for admission to the program must submit an application to the commission that conforms to requirements established by the commission.

(5) In selecting participants for the program, the board may only accept an applicant if his or her academic record and other characteristics, if given consideration by the University of Mississippi School of Dentistry Admissions Committee, would be considered credible and competitive.

(6) An applicant for the program may be admitted only upon a majority vote of the members of the commission.

(7) Up to three (3) students will be admitted to the Mississippi Rural Dentists Scholarship Program each year.

SECTION 5. The following provision shall be codified as Section 37-146-9, Mississippi Code of 1972:

37-146-9. **Participants to adhere to program policies and practices to remain in program; forgiveness or repayment of financial assistance under certain circumstances.** (1) Participants must adhere to the policies and practices as stipulated by the commission to continue in the program.

(2) Students in the program may receive tuition or other financial support that may be provided by the commission. If a student in the program is admitted to and completes dental school, any tuition or other educational and living support provided to the student by the commission will be forgiven. However, if the student is not successful in being accepted into dental school within three (3) years of entry into the Mississippi Rural Dentists Scholarship Program, or if the student otherwise breaches his or her agreement with the commission, all financial assistance provided to the student must be repaid according to policies adopted by the board.

SECTION 6. The following provision shall be codified as Section 37-146-11, Mississippi Code of 1972:

37-146-11. **Participants may apply to the accredited dental school in Mississippi; early admissions process for students applying to University of Mississippi School of Dentistry.** (1) Students in the program may apply to the Mississippi Dental School.

(2) Students in the program seeking admission to the University of Mississippi School of Dentistry shall be eligible for the admissions process pursuant to criteria established by the School of Dentistry Admissions Committee which will include consideration of the attributes of participation in the program.

(3) In carrying out the admissions process developed for the Mississippi Rural Dentists Scholarship Program participants under this section, the goal is for the program to work with the School of Dentistry to enhance the capability of participants to successfully enter and complete dental school and enter practice in rural or underserved areas in Mississippi. To the extent feasible, the early admissions process should be completed before December 1 of the year preceding a student's admission to dental school.

SECTION 7. The following provision shall be codified as Section 37-146-13, Mississippi Code of 1972:

37-146-13. **Ongoing financial support for program participants who attend dental school; preference for ongoing support to University of Mississippi School of Dentistry students; students obligated for one year of**

practice for every year of financial assistance

received. (1) Subject to the availability of funding, students in the program who successfully matriculate to dental school are eligible for ongoing financial support in accordance with policies and requirements of the commission and in accordance with the applicable laws and regulations. The number of students to be supported at the University of Mississippi School of Dentistry and at other schools will be established by policy prescribed by the commission.

(2) Subject to the availability of funding, students enrolled at the University of Mississippi School of Dentistry may receive tuition support, funding to assist with the cost of books and a living stipend, as prescribed by policy of the commission and in accordance with applicable regulations. Preferences for ongoing funding must be given to those students admitted to the University of Mississippi School of Dentistry.

(3) For each year that a student in dental school receives financial assistance, the student is obligated for one (1) year of practice as a dentist in a rural or underserved area in Mississippi. Breach of the agreement at any stage of training shall invoke the repayment of all financial assistance provided to the student through the Mississippi Rural Dentists Scholarship Program along with other penalties that may be prescribed in policy by the commission.

SECTION 8. The following provision shall be codified as Section 37-146-17, Mississippi Code of 1972:

37-146-17. Program participants required to enter practice of dentistry in health professional shortage, rural or underserved area upon completion of residency for number of years corresponding to number of years assistance received up to maximum of five years; breach of contract; liability for repayment. (1) Upon completion of dental school and/or a dental residency program approved by the commission, a participant in the Mississippi Rural Dentists Scholarship Program must proceed to enter the full-time practice of dentistry in a rural or underserved area in Mississippi, as defined by the commission and consistent with generally acceptable designations. If an area experiences significant changes in its dental or general community which are not reflected by dental health professional shortage area (HPSA), the commission may receive testimony and, in its discretion, may qualify the area as a dentally underserved or rural area to allow the program participant to fulfill his or her practice obligation.

(2) Upon entering the practice of dentistry, a participant in the program must serve in a dental health professional shortage area (HPSA) or rural area otherwise approved for practice under subsection (1) of this section for a number of years which corresponds to the number of years, not to exceed five (5), for which the

participant received funding through the program. Any participant who fails to complete the period of practice for which he or she is obligated to provide services in a dental health professional shortage area (HPSA) or rural area in exchange for financial assistance received through the Mississippi Rural Dentists Scholarship Program shall be liable for the repayment of all financial assistance provided to the participant through the program, along with other penalties that may be prescribed by the commission, an amount which shall be reduced on a pro rata basis for actual years of practice by the dentist in the area designated by the commission.

SECTION 9. The following provision shall be codified as Section 37-146-19, Mississippi Code of 1972:

37-146-19. **Initial practice entry support system for program participants.** The Mississippi Rural Dentists Scholarship Program, acting through the commission, shall make an effort to establish an initial practice entry support system for participants in the program.

SECTION 10. The following provision shall be codified as Section 37-146-21, Mississippi Code of 1972:

37-146-21. **Limitation of program and commission governing and administrative authority.** This chapter may not be construed as granting the Mississippi Rural Dentists Scholarship Program or its governing commission any governing or administrative authority over any program administered by any college, university, dental

school or residency program in this state or any other program established by state law.

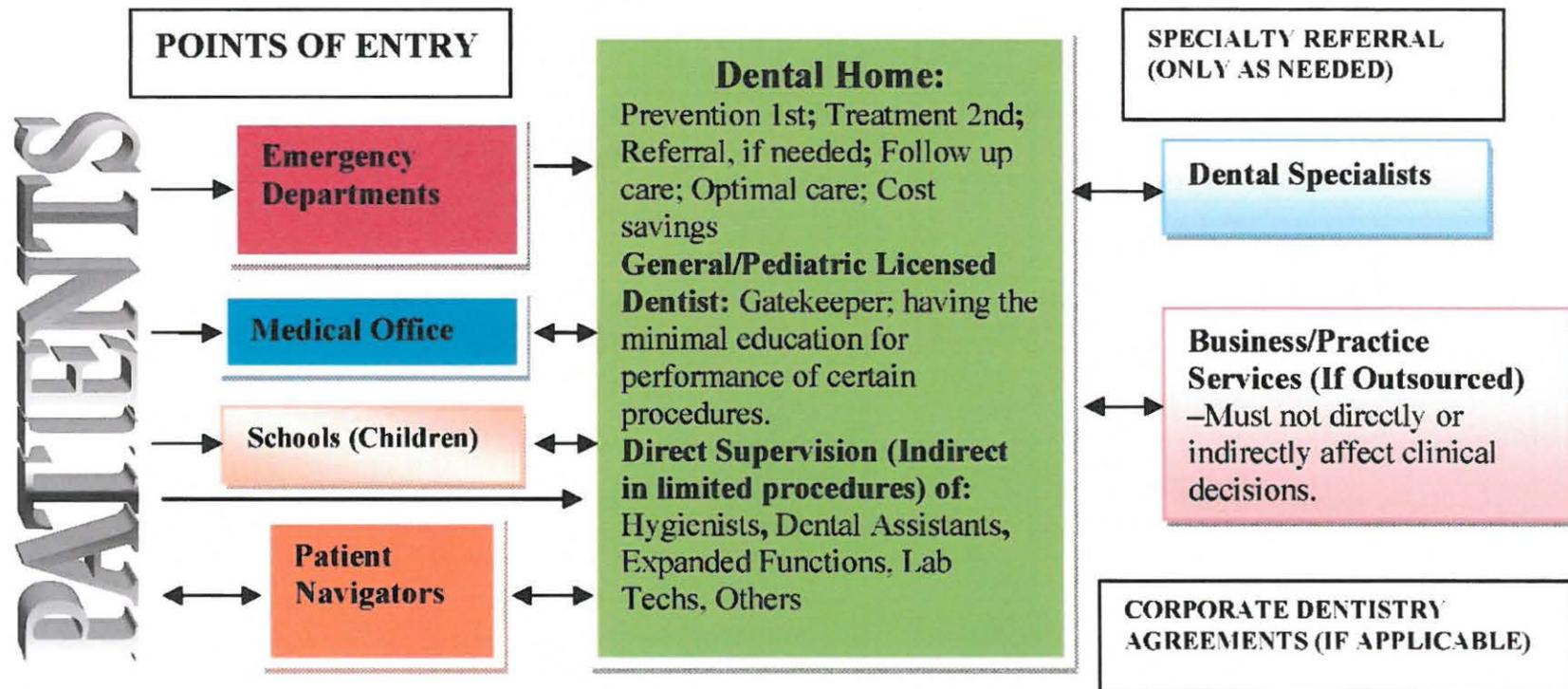
SECTION 11. This act shall take effect and be in force from and after July 1, 2013.

Dental Team Concept

An Excerpt from the Academy of General Dentistry's (AGD)

*Optimal Delivery of Oral Health Services through Primary Care: A Comprehensive Workforce Policy Statement**

The following diagram provides a visual representation of the dental team concept to include a snapshot of contemporary considerations in the delivery of oral health care and the role of the dental home therein. However, the points of entry or other representations in the diagram are not intended to be limiting in the scope of the concept or in the position of the AGD.



* Pending approval as official AGD policy. © 2014 Academy of General Dentistry.



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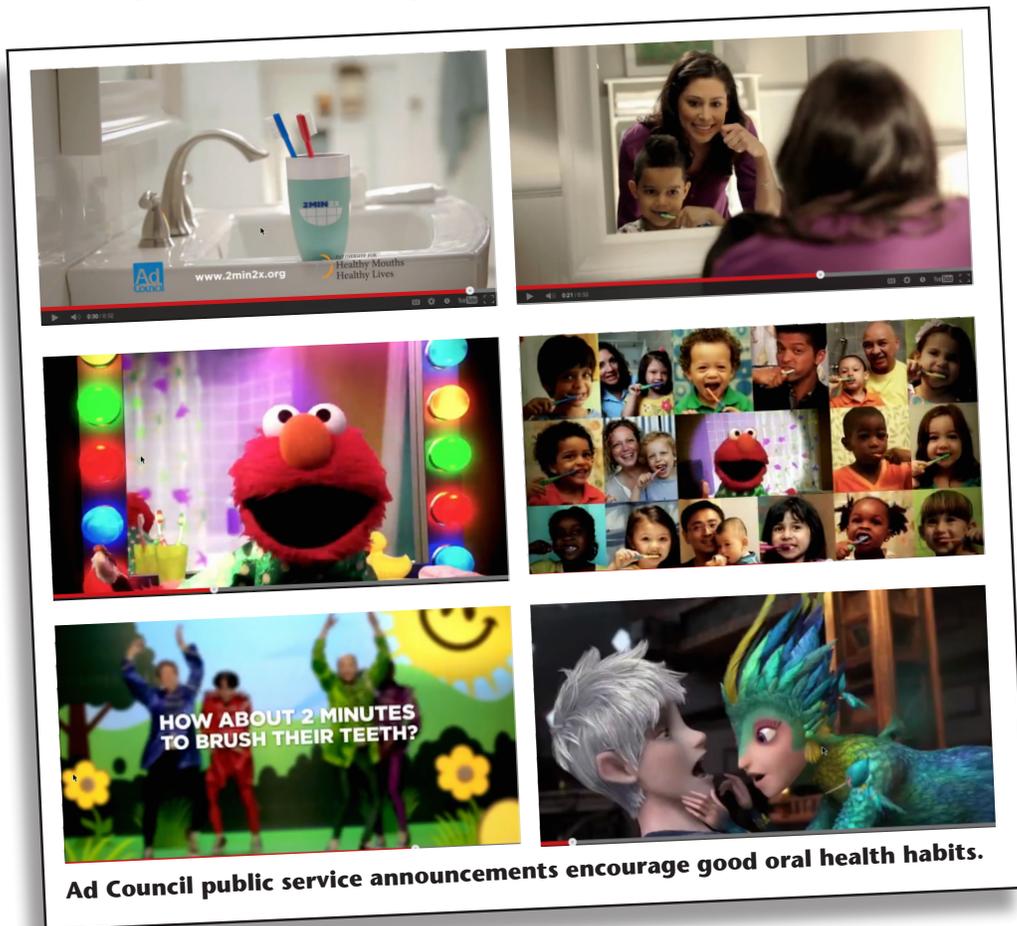
AGD Supports Children's Oral Health Campaign



The Academy of General Dentistry (AGD) is a member of the Partnership for Healthy Mouths, Healthy Lives, a first-of-its-kind national dental coalition composed of 35 leading dental health organizations.

The Partnership has collaborated with the Ad Council to create television and radio public service advertisements, in both English and Spanish, which explain why it's important that children brush their teeth for two minutes twice a day.

The campaign also provides parents and caregivers with resources through a special campaign website, www.2min2x.org.



"Patients—especially our younger ones—are inundated with ads for products that can hinder their oral health. Sometimes it feels like they only hear about caring for their mouths when they visit the dentist's office. But now there is another way to help children and their parents learn to develop good oral health habits at an early age."

— AGD Immediate Past President
Jeffrey M. Cole, DDS, MBA, FAGD



"Childhood dental decay is largely preventable, and there are many simple, inexpensive ways that parents and caregivers can improve their children's oral health. Our hope is that this campaign will instill behaviors that will result in a lifetime of good oral health."

—AGD Secretary Manuel A. Cordero,
DDS, MAGD



General Dentists and the AGD

A general dentist is the primary care provider for patients of all ages and is responsible for the diagnosis, treatment, management, and overall coordination of services related to patients' oral health needs. The Academy of General Dentistry (AGD) is a professional association of 38,000 general dentists dedicated to providing quality dental care and oral health information to the public.

To contact the AGD's advocacy department, call 888.AGD.DENT (888.243.3368), ext. 4321, or email advocacy@agd.org. In Washington, D.C., call the AGD lobbyist's office at 202.223.6222. For more information, visit www.agd.org.





The Academy of General Dentistry at a Glance



What is the Academy of General Dentistry?

The Academy of General Dentistry (AGD) is a professional association of 38,000 members from across the United States. Founded in 1952, the AGD has grown to become the country's second largest dental association, and it is the only association that exclusively serves the needs and represents the interests of general dentists. The organization also works to promote the oral health of the public and to foster general dentists' continued proficiency through quality continuing education. AGD Headquarters is located in Chicago.



What is a general dentist?

General dentists are the primary oral health care providers for patients of all ages. General dentists take responsibility for the diagnosis, treatment, and coordination of services to meet patients' oral health needs. If a specialized dental procedure is needed, general dentists may work with specialists to ensure that patients receive the necessary care.



How does dentistry affect the economy?

Dentists are some of America's most highly educated and trained health care professionals. The majority of our nation's dentists practice in small-business environments in their local communities. Collectively, the direct, indirect, and induced impact of dentists is estimated to exceed \$200 billion annually. More than 772,000 people are employed directly in the field of dentistry; when indirect and induced impacts are included, the total employment attributable to dentistry rises to more than 2 million jobs.



What resources does the AGD offer the public?

Kids' Healthy Mouths Campaign: The AGD is a member of the Partnership for Healthy Mouths, Healthy Lives, which collaborated with the Ad Council to create the Kids' Healthy Mouths campaign. Designed to educate parents and caregivers on how to improve their children's oral health in simple ways, the campaign encourages children to brush their teeth for two minutes, twice a day, and offers families oral health resources through the website 2min2x.org.

KnowYourTeeth.com: This website is the AGD's source of consumer information on dental care and oral health. Its goal is to provide reliable information in a format that is easy to use and navigate, and to provide the tools that will help consumers of all ages to care for their teeth and with other aspects of oral care. KnowYourTeeth.com answers important dental health questions, offers the latest information on current dental treatments and tips for first-rate oral hygiene, and can help visitors find qualified dentists near where they live or work.



Where can I find more information?

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