



# 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 days of lost workdays each year. 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 complication 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;
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 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
- k. Increase general dentists' understanding of the benefits of treating indigent populations;
- 10. Establish alternative oral health care delivery service units:
  - a. Provide exams for one-year-old children as part of the recommendations for new mothers to facilitate early screening
  - b. Provide oral health care, education, and preventive programs in schools
  - c. Arrange for transportation to and from care centers
  - d. Solicit volunteer participation from the private sector to staff the centers;
- 11. Encourage private organizations, such as Donated Dental Services (DDS), fraternal organizations and religious groups to establish and provide service;
- 12. Provide mobile and portable dental units to service the underserved and indigent of all age groups;
- 13. Identify educational resources for dentists on how to provide care to pediatric and special needs patients and increase AGD dentist participation;
- 14. 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;
- 15. Pursue development of a comprehensive oral health education component for public schools' health curriculum in addition to providing editorial and consultative services to primary and secondary school textbook publishers;
- 16. Increase supply of dental assistants and dental hygienists to engage in prevention efforts within the dental team;
- 17. Expand the role of auxiliaries within the dental team, including a dentist or under the direct supervision of a dentist;
- 18. Eliminate barriers and expand the role that retired dentists can play in providing service to indigent populations;
- 19. Strengthen alliances with American Dental Education Association (ADEA) and other professional organizations like the Association of State and Territorial Health Officials (ASTHO), Association of State and Territorial Dental Directors (ASTDD), National Association of Local Boards of Health (NALBOH), National Association of County & City Health Officials (NACCHO) and so forth;
- 20. 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
- 21. Increase funding for fluoride monitoring and surveillance programs, as well as for the development and promotion of 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.

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."

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) maldistribution 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, US 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 Provider** —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.

**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 experienced lowered 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; alternatively, it 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 undeserved 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.

- 1) Those funds could be used to increase the numbers of dentists being trained, as well as training for expanded duties assistants.
- 2) 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.
- 3) 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."

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 supervision and from diagnosing conditions of oral health regardless of supervision.

Notwithstanding the inherent injustice in providing lesser quality and potentially 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.

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. The groundbreaking release, *Oral Health in America: A Report of the Surgeon General*, in May 2000 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. 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 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:
  - a) The council developed a Dentalnotes story, “Dental Sealants—Is Your Child a Candidate?” which included

information obtained from the CDC and referenced the Healthy People 2010 objectives related to sealants;

b) 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;

c) The council 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

d) The council hosts 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.

3) 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.

4) 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;
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 serving other disadvantaged populations, and HHS-wide loan repayment authorities;
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 areas where these patients in the underserved areas 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.

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 the indigent.
- 2) Establish alternative oral health care delivery service units:
  - a) Provide exams for one-year-old children as part of the recommendations for new mothers to facilitate early screening;
  - b) Provide oral health care, education, and preventive programs in schools;
  - c) Arrange for transportation to and from care centers; and
  - d) Solicit volunteer participation from the private sector to staff the centers.
- 3) Encourage private organizations, such as Donated Dental Services (DDS), fraternal organizations, and religious groups to establish and provide service;
- 4) Provide mobile and portable dental units to service the underserved and indigent of all age groups;
- 5) Identify educational resources for dentists on how to provide care to pediatric and special needs patients and increase AGD dentist participation;
- 6) Provide information to dentists and their staffs on cultural diversity issues that will help them reduce or eliminate

- barriers to clear communication and enhance understanding of treatment and treatment options;
- 7) Pursue development of a comprehensive oral health education component for public schools' health curriculum in addition to providing editorial and consultative services to primary and secondary school textbook publishers;
- 8) Increase supply of dental assistants and dental hygienists to engage in prevention efforts within the dental team;
- 9) Expand the role of auxiliaries within the dental team including a dentist or under the direct supervision of a dentist;
- 10) Eliminate barriers and expand the role that retired dentists can play in providing service to indigent populations;
- 11) Strengthen alliances with ADEA and other professional organizations, such as the Association of State and Territorial Health Officials (ASTHO), Association of State and Territorial Dental Directors (ASTDD), National Association of Local Boards of Health (NALBOH), National Association of County & City Health Officials (NACCHO) and so forth;
- 12) 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
- 13) 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 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 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."

## **ACKNOWLEDGEMENTS**

The Academy of General Dentistry (AGD) White Paper on Increasing Access to and Utilization of Oral Health Care Services (White Paper) was developed by the Board of Trustees (the Board) Task Force on Access to Care in collaboration with task force consultants, Dental Care (DC) and Legislative & Governmental Affairs (LGA) Councils, the Division Coordinator to the DC and LGA Councils, the Executive Committee, AGD Staff, and the Special Consultant to the Task Force. The White 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 2008



## AGD – An Urgent Message from Your President

Dear AGD Members,

Two weeks ago, you received an email from the Academy of General Dentistry (AGD) providing you with information about the American Dental Association's (ADA) Community Dental Health Coordinator (CDHC) and a related resolution at the upcoming ADA House of Delegates. We asked you to contact your ADA delegates and alternates and ask for them to oppose this costly measure. Many of you have, and we *thank you*.

Please know that you may have resistance when making the calls. This is not a recruitment campaign for the AGD and we are not trying to be divisive. We are informing our members of the actions of the ADA and how it will affect the practice of general dentistry and the patients we treat. We are then asking those members to take action by contacting their ADA representative and sharing those concerns. It is not divisive for ADA members share their viewpoints to their ADA delegates.

AGD is being proactive by advocating its [White Paper on Access to Care](#). There are over **30 positive possible solutions**, which have not been seriously tried or advocated by any group in a comprehensive manner. On behalf of the AGD Board of Trustees, I have recorded a message for you. Please [click on this link or the image above](#) to be better informed on the CDHC issue and AGD's White Paper.

Thank you for all that you have already done for general dentistry, and all that you will accomplish in the coming month.

Sincerely,  
Paula Jones, DDS, FAGD  
President, Academy of General Dentistry  
Member, American Dental Association



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Dear Delegates and Alternate Delegates:

For the past eight years, I have made it my mission, first as Treasurer and later as President-Elect and President, to ensure that the ADA House of Delegates had accurate information on which to make decisions. I believe that honest, accurate information is critical to both the Board's and the House's abilities to lead the ADA responsibly and effectively.

Appended you will find two documents that respond in detail to recent, inaccurate statements widely distributed by the Academy of General Dentistry (AGD). I apologize for their length. But I feel strongly that the House needs a detailed response to these statements.

It is in that context that I express my strong dismay at some of the information being disseminated by the AGD about the ADA's Community Dental Health Coordinator (CDHC) initiative. As those of you who have served in the House these past years and followed the development of the CDHC model know, its purpose is to develop and deploy a new member of the dental team under a dentist's supervision, who would act as a bridge between underserved communities where access to dental care is lacking, and fully qualified, licensed dentists who would provide care to those with the greatest, most immediate needs. The CDHC would not perform surgery, even to the extent of being specifically trained and instructed not to remove caries.

The ADA has been completely transparent with its leaders and members about every aspect of the CDHC project since its inception—the development of a specific scope of practice, a curriculum to teach that scope, the places where CDHCs would work and how they would interact with supervising dentists—and it has not changed in concept or scope from its initial presentation passed by the House in 2006 and widely supported in 2007. I and the other members of the Board of Trustees were therefore shocked when the AGD began widely distributing e-mails and placing videos on YouTube that paint a totally false picture of the CDHC, charging that the original model had "morphed" into a "mid-level provider" that would perform "irreversible dental procedures" (unless you consider applying a sealant or removing surface debris from a tooth upon a dentist's order to be an irreversible dental procedure). Please find appended a Q and A on the CDHC which should answer any questions you might have about the model.

Further, the ADA House is not being asked to "spend" \$5 million on the CDHC project, as stated in two AGD e-mails. Resolution 39 carries no current financial implication and is a statement of commitment from our profession to help as we go out and raise *outside financial support*, which has always been our goal. These and other statements made in the AGD communications are untrue, and the AGD leaders should know this.

Giving the benefit of a doubt, Dr. Findley and I invited AGD President Dr. Paula Jones to meet with us a few days after her first message appeared. We also invited to the meeting Dr. Bob Brandjord, former ADA president and the author of the CDHC program, to help lay to rest the AGD's fears. Based on our conversation that day, I thought we had succeeded in doing so. I was wrong.

Two weeks after the initial AGD message appeared, the organization repeated its claims about the CDHC and continued promoting its answer to the access problem with a white paper containing, according to them, "30 positive possible solutions, which have not been seriously tried or advocated by any group in a comprehensive manner." Again, this is not accurate, which is especially unfortunate, as the AGD list contains many commendable and viable policy goals, *most of which the ADA has been actively advocating for years*. The second document I have appended to this message makes this all abundantly clear. While we certainly intend to keep up the multi-faceted approach to providing access to care, it is very clear to those states already facing legislative challenges that a proven model keeping the dentist as the head of a team providing care is badly needed at this time.

None of this is intended to influence the House's votes or actions during our coming session. My purpose is to do the best job that I can to ensure that the House has accurate information—rather than misinformation—on which to base those votes and actions.

This has been an interesting and rewarding year, although occasionally difficult, as well as the 25th year that I have been privileged to serve in this House. And certainly, the rewards have far outweighed the difficulties. I am confident that we can resolve our differences with the AGD over the critical job of improving access to care for the millions of Americans who currently lack it. When the facts come out, I really don't think our differences amount to much at all.

Sincerely,

A handwritten signature in black ink that reads "Mark J. Feldman DMD". The signature is written in a cursive style with a large, stylized initial "M".

Mark J. Feldman, DMD  
President

October 6, 2008

Dear [ADA Delegate]

Like most of you, the leadership of the Academy of General Dentistry (AGD) has read the e-mail blast which the American Dental Association (ADA) leadership sent to its delegates on October 1, regarding the AGD's position on the Community Dental Health Coordinator, (CDHC). Understand that this is not an ADA vs. AGD issue. This is a dentistry issue. Many non-AGD members, both specialists and general dentists, have voiced their concerns as well. These concerns are much more all-encompassing than both the AGD and the ADA. We are deliberating on the future of our profession and the dental health of millions of Americans.

The AGD has long been a strong supporter of the ADA agenda and initiatives, both on and off Capitol Hill. We continue to visibly support the ADA's numerous positions on Medicaid, student loan forgiveness, general practice residency programs, and other issues. However, we feel that the level of attention and financial support should be directed more on these initiatives and less on the development and pilot programs for the CDHC. This is based on the fact that, unlike the CDHC, these other initiatives have been proven to work. We would like to see greater effort and energy be utilized to allow these initiatives to become reality.

With the exception of our Canadian colleagues, all of the members of the AGD Board of Trustees are dues paying members of the ADA. Many hold leadership positions in the ADA. So, as dedicated ADA members, we feel that the proper place to render our position on ADA activities would be "in house" in San Antonio. The AGD did this last year in San Francisco by joining with the ADA leadership in arguing for the proposed ADA Sedation Guidelines. And, in this vein, we owe it to the ADA to voice our concerns, while keeping it "in the family," in San Antonio.

Bolstered with valid information, the AGD leadership will continue to share its talking points that address our concerns with the continued development of the CDHC. And, with the overwhelming support of our Board of Trustees, the AGD leadership will continue to stand behind this position, which has not wavered. We will further communicate these talking points to you in San Antonio, and will be more than happy to answer any questions, or address any concerns, that you may have.

Good, healthy, debate on important issues such as this is not uncommon at both the ADA and AGD House of Delegates sessions. To disagree is not being divisive. And voicing an opposing view should be accepted in the constructive spirit in which it was intended. In the end, we will all abide by the wisdom of the ADA House of Delegates. No matter what the outcome might be, we will continue to be proud ADA members.

Should you have any questions, please forward them to AGD at [advocacy@agd.org](mailto:advocacy@agd.org).

Sincerely,

A handwritten signature in black ink that reads "Paula S. Jones, DDS, FAGD". The signature is written in a cursive, flowing style.

Paula S. Jones, DDS, FAGD  
President, Academy of General Dentistry  
Member, American Dental Association