PLENARY SESSION: HOT TOPICS- WHAT’S UP WITH DENTISTRY?

National Primary Oral Health Conference
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Frank Catalanotto, DMD
Professor and Chair of Community Dentistry and Behavioral Science
University of Florida College of Dentistry
352-273-5970
fcatalanotto@dental.ufl.edu
So, what are the hot topics, a totally personal perspective?

- **Access** to oral health care

- (Selected) **Ethical** issues for oral health professionals

- **Workforce**- Medical personnel- About 40 state Medicaid programs now reimburse medical personnel for ECC preventive procedures.

- **Workforce**- Midlevel providers- Opposition and evidence. What is up with this Austin Group? The Boston Group? The enlightened ADA???

- **Workforce**- More dentists- is that the answer to access problems? More dental schools? New models of dental education- the Osteopathic model? Where is the research basis? Are we turning into a trade?

- **Government and foundation intervention**- Federal Trade Commission intervention in South Carolina, Louisiana and Alabama. PEW, Kellogg, California Endowment etc supporting new initiatives including midlevels.

- **Health care reform**- what is in there for oral health?
Learning Objectives

1) Discuss some issues impacting the access to oral health problem.

2) Describe some ethical issues related to professional obligations of care for the underserved.

3) Describe the role of the medical team in prevention of early childhood caries.

4) Discuss the evidence base for and against the use of midlevel oral health professionals.

5) Describe the concerns about new models of dental education.

6) Discuss implications of intervention into self-regulation of professions.

7) List several of the oral health provisions of health care reform legislation.
Access to oral health care

• What is the access problem?

• What are some of the solutions?
  - more dentists- look at all the new schools
  - more pro bono care
  - new models of care- medical team, mid-levels, etc,
  - expanded function for existing dental personnel
  - more education of the public about the importance of oral health
  - more insurance, higher reimbursement, decreased administrative hassles (ADA answer)
What is the access problem?

- People in need cannot access care- the system works for some but not all!

- Need versus demand? The **ADA argument** that demand is not there- there are enough personnel to meet demand? The **public health argument** that people need care they do not realize they need- we need more personnel to reach them.

- Restrictive dental practice acts? Increased mobility, flexibility, using existing personnel to their full ability.

- Oral health literacy? Related to the need vs. demand issue

- Bad choices on the part of certain patient groups. Also related to the need vs. demand issue.
People in need cannot access care- the system works for some (the middle class and those with private insurance) but not all!

- Deamonte Driver and other deaths
- Costs of dental disease
- Data from Florida as an example
By the time Deamonte’s tooth got attention, the infection had spread to his brain, and after two operations, Diamonte passed away 6 weeks later.
Some additional material

- Deamonte's bill for two weeks at Children's Hospital alone was about $225,000.

- A routine $80 tooth extraction might have saved him.  
  If his mother had been insured.  
  If his family had not lost its Medicaid.  
  If Medicaid dentists weren't so hard to find.  
  If he had received several applications of fluoride varnish and parental education in his younger years, applied by his pediatrician or family physician.

While one might understand his mother having trouble navigating the health care system, even his legal aid attorney was unsuccessful in getting him to a dentist- finding a dentist to take medicaid.

There have been at least 3 other deaths since 2006 that we know about in Mississippi, New York, most recently, a disabled adult Medicaid recipient in Michigan.
Cost of Dental Disease

- Nationally, an estimated 60 billion dollars is currently being spent on dental treatment services.

- **School days lost** – estimated 51 million hours/year.

- Work days lost – estimated 164 million hours/year.

- As more people live longer and keep their teeth longer, there is a greater need for access to dental care services.

- Does not include pain and suffering.

- School nurses in Florida report that dental problems are one of the leading causes of missed school days.
Relevant Florida Data
And similar data in many other states

• Only about 10% of Florida’s 9,496 dentists participate in Medicaid.

• Only about 26% of Florida Medicaid recipients receive dental services and only about 10% of children under the age of 6 receive any dental services; ratio of Medicaid dentists to eligible children is 1:7,610

• There are about 400,000 Medicaid eligible children under age three in Florida including those in traditional Medicaid and managed care programs.

• Only about 4.1% of adult Medicaid patients receive any dental care. The adult benefits are minimal except full mouth extractions and dentures; ratio of Medicaid dentists to eligible adult population is 1:35,393

• During 2000-2003, on average per year, 1200 Medicaid recipients under 6 years of age had dental work done under general anesthesia.

• From July 1-2006-June30, 2007, 196 Medicaid recipients under age 6 were admitted to Florida hospitals for a life threatening dental infection.

• Only 5 of Florida’s 67 counties are NOT classified as a DHPSA; it would take approximately 750 (range 400-1,000) full time dentists to fill these needs.

CONCLUSION: Things are not good in oral health in Florida
Need versus demand? The ADA argument that demand is not there?

- The ADA continually talks about need versus demand. The position is that there are enough dentists (& other personnel) to meet the level of care demanded by the public (maybe demand is low because of high fees and lack of knowledge of the public about importance of oral health) and there is enough capacity in the system to meet some increased demand if it occurs. The public health perspective is that there are not enough dentists to meet actual needs of the public. Increased oral health literacy could increase demand (also supported by ADA)! (note Health Care Reform support for public education).
Dental License/Dental Practice Acts

• The purpose of licensing is to protect the public. What else is there?
• Protect public safety through setting and enforcing reliable, consistent standards
• Serve the public interest by ensuring supply
• Promote competition and consumer choice
• Implement statutes enacted by legislature

Modified from a Gehshan PEW slide
Restrictive Dental Practice Acts

• STATEMENT: Protecting the public- “We have our own exam in Florida because our patients are different than in other states- older, more medically complex, so we have to keep out the incompetents.” (I think he meant more New Yorkers like me)!

OR

• MY INTERPRETATION: Restrictive practices decrease competition and increase income
There is a body of literature on restrictive practices in dental licensing!


- **Freund, Deborah** and **Shulman, Jay**, *Regulation of the Professions: Results from Dentistry*, *Advances in Health Care Economics and Health Services Research*, 5:161-180, 1984

- And more, just write me if interested in references
Restrictive Licensing #1

- Restrictive dental licensing leads to higher costs and no improvement in quality*
- Stricter regulation leads to increases in dentists’ income
  - Higher earnings in more regulated states than in least regulated states (Kleiner and Kudrle, 2001)
  - Higher incomes in states with restrictive use of reciprocity agreements (Holen, 1965)
  - Dental board testing standards and reciprocity arrangements protect dentists’ incomes (Maurizi, 1974; Conrad and Emerson, 1981)
- So, I ask, if not protection of public why bother??
- Modified from Gehshan PEW slide
Restrictive licensing- #2

- Doyle- Based upon employment trends of the five best-paying professional occupational groups, the concern that licensing inhibits job growth does not seem justified in most cases—engineering, accountancy, law and medicine have all grown substantially. **Meanwhile, dentistry has not- “studies suggesting that it has the most restrictive licensing practices of the traditional professions.”** AND a disproportionately high income.
Restrictive licensing - #3

• If it is safe for dental hygienists to do sealants without direct supervision or infiltration anesthesia in other states, why is it not safe in Florida.

• First answer the “different, older population”. Second answer, quietly, “if you let the camel stick its nose under the tent, the hump will be in next”.

• Interpret that as you wish.
Bad choices on the part of some patients
Oral Health Literacy

• You know, I saw this patient in the cash register line at the supermarket and they were paying with food stamps and they had on the newest basketball shoes, and a new model of a cell phone and and and and and and.

• I actually heard this from a former chair of the ADA Council on Ethics.

• “Patients just need to prioritize their oral health needs higher.”

• But when your income is so low, can this work?

• Good news is the oral health public education and prevention program as one of the HCR agenda items
What are some of the solutions?

- more dentists will improve access??- look at all the new schools! But will it really do this??
- more pro bono care
- new models of care- medical team, mid-levels, etc,
- expanded function for existing dental personnel
- more education of the public about the importance of oral health
- more insurance, higher reimbursement, decreased administrative hassles (ADA answer)
Not enough dentists? Other health care providers?

- Do we really need more dentists? Will more dentists solve the access problem? (we have about 750+ DHPAs in Florida). Based upon the medical model, more dentists will not improve access! And creating dentists is expensive! 50k annual tuition plus start up costs!
- Midlevels and other new providers- We think they are less expensive to educate but they do need to be paid!
- Medical Providers- this model works- evidence is there; and it focuses on PREVENTION and EDUCATION.
- Allowing dental hygienists to do what they are trained to do. Lots of underemployed DHs. This is where restrictive dental practice acts might come in.
New Models for Dental Providers

I am not going to review them, just the concept
And later in talk, the ethical issue of opposition!

- ADA model — Community Dental Health Coordinator (similar to Primary Dental Health Aides in Alaska)

- ADHA model — Advanced dental hygiene practitioner

- Dental Health Therapist or a Pediatric Oral Health Therapist (a dental therapist specializing in kids)
Midlevel providers—Opposition and evidence. What is up with this Austin Group and the Georgia Dental Association?

• Later this morning, Shelly Gehshan/Bill Maas will be discussing New Workforce Models and What they might mean for Health Centers. I assume that will cover a variety of midlevel descriptions.

• I want to focus on the controversy being generated by this topic, using the New Zealand Model as an example.
New Zealand - Suggested Recommendations

Dental Therapist Recruitment & Retention

• DHBs implement a national recruitment drive to raise the dental therapy profile.

• Introduce educators and assistants nationwide (where not currently practising) to maximise dental therapist clinical time – recruit a proportionate number of Maori and Pacific.

• DHBs implement a national review of dental therapy salary and conditions of employment.

• Provide dental therapy scholarships – provide a proportionate number for Maori and Pacific. (Dependent on funding)

• Market dental therapy to young people – target Maori and Pacific.

• Consider the development of postgraduate studies to up skill and extend dental practice.

• Reduce travel and administration duties in order to increase clinical time.
District Health Boards (DHBs) have recently conducted a national review of School Dental Services. **Initial findings of the review indicate a service that is under threat.**
June 22, 2010
TO: Austin Group Representatives from Texas, Louisiana, North Carolina, and Delaware
FROM: Kent Percy, President (Georgia Dental Association)

• “New Zealand has employed MLPs since 1921. If this strategy had been successful, New Zealand would not be experiencing pockets of oral health disease at the level of regions traditionally characterized by poor oral health status. Indeed, in some areas the severity is at the level of developing or Eastern European countries. Recent data prompted New Zealand to reconstruct its dental delivery system. What this information underscores is that merely creating different types of providers to augment care from a dentist does not provide appropriate and accessible oral health care. “
Are more dentists the answer to Access Problems?

• 5 accredited dental schools have opened since 2000
  – Nova Southeastern, University of Nevada-Las Vegas, Arizona School of Dentistry and Oral Health, Midwestern University (Arizona Campus), Western University of Health Sciences

• 4 new dental schools are seeking accreditation and have hired faculty and are moving along in process.
  – East Carolina University, Lake Erie College of Osteopathic Medicine (Bradenton Florida campus), Midwestern University (Chicago Campus), University of Southern Nevada (South Jordan Utah campus)

• 13 (at least) new dental schools are under consideration
  – Arkansas, California (2), Florida (2, in Orlando and Tallahassee), Kansas, Maine, New Mexico, Ohio, Texas, Utah, Virginia, Wisconsin
New dental Schools- the Osteopathic medical model and the need for a research base- another part of the controversy

- The only new dental school associated with a major research intensive university in the last 40 years was UFCD.
- All other schools are associated with osteopathic medical schools or non-research intensive universities (except ECU).
- Are their goals to improve access by producing more dentists, seek prestige of having a dental school on campus, or making money!
Division in the ranks

• A group of research intensive schools has met to discuss this issue- they consider it a major problem.

• Many believe the key to change/progress in our profession from barber surgeon era to respected professional came about when education moved to universities.

• Research and improved technology is the key to future treatments and improvements in oral health.

• The concern may be that before this new growth, we always had RI and non-RI schools BUT now we have lots more non-RI schools- that shift is a concern for the future.

• RESEARCH STANDARDS IN CODE BEEFED UP A BIT
THE MEDICAL MODEL

What can you do as a medical/health care practitioner who sees young children?

Consistent with Florida Medicaid Requirement
Now in about 40 other states and growing

• Oral screening examination as part of a well child checkup.

• Risk assessment, which should include assessment of mothers’s/caregiver’s oral health.

• Application of Fluoride Varnish

• Anticipatory Guidance/Parental Education including dietary and oral hygiene information

• Try to make a referral to a Dental Home
FLORIDA: Effective immediately, 4/15/2008, Medicaid will cover the application of fluoride varnish when provided to beneficiaries in a physician’s office.

- Physicians should use CPT code 99499 with modifier SC V07.31 (medically necessary service).
- The procedure includes an oral evaluation, risk assessment, diagnosis code 521.01, parental counseling, application of varnish and referral to a dentist.
- The fluoride varnish procedure may be billed once every 3 months up to age 42 months (even though official announcement says 3 years of age).
- Procedure code 99499 SC V07.31 reimburses physicians, ARNPs, and PAs $27.00.
- The procedure may be submitted once per claim on the same date of service as other procedures.
More Billing Information

• When provided in a county health department (CHD) or federally qualified health center (FQHC), fluoride varnish must be billed using the CHD or FQHC fee-for-service group provider number. The treating provider number must be entered in item 24J on the 1500 claim form.

• Managed care plans are required to allow the additional provider type to be reimbursed for the service.

• Fluoride varnish may also be applied to a child’s teeth at the time of the Child Health Check-Up visit. It can be billed with procedure code 99499 SC, as noted above, in addition to the Child Health Check-Up visit code(s).

• If a child comes to the office for immunizations, the oral evaluation and fluoride varnish can be provided during the same visit and billed using 99499 SC V07.31 in addition to the immunization service.

• SCHIP and Medikids are eligible for this service.
More Billing Information

• This program was established to prevent early childhood caries and to refer the child to a dentist before severe decay and a toothache occurs. The caregiver should be informed that the child needs to be seen by a dentist for follow up treatment. If a dental provider is not available in an area, physicians should notify the health plan (if the recipient is enrolled with a health plan that covers dental services) or area Medicaid office if the recipient is in a fee-for-service Medicaid or Medipass) that the child needs a dental visit.
Medicaid Billing FAQs

- Can any of these procedures be delegated? Under the direct supervision and responsibility of a licensed physician, ARNP, or PA, an RN, LPN, or a medical assistant may apply fluoride varnish and give parental education. However, only the physician, ARNP or PA may be reimbursed by Medicaid for the service.

- What does 90 days mean? You cannot be reimbursed more than once per every 90 day period.

- The primary diagnosis code for dental caries is 521.01; the treatment code is CPT code 99499 V07.31.
So, how are we doing in Florida?
Billings May, 2008 thru June 30, 2010

• Includes Paid fee-for-service Medicaid Claims and most managed care claims
• 456 billing providers
• 34,894 unduplicated recipients
• 51,795 Duplicated counts (total # of procedures)
• 45 counties
• Includes 403 individual physicians, 15 ARNPs, 6 CHDs, **8 FQHCs**, 7 HMOs and 7 “others”
• Includes managed care patients and even in managed care REFORM counties- cannot figure out who gets paid and why?
• BUT, we also know that penetration is much lower than expected in Managed Care Reform counties like Dade and Duval, compared on a per capita basis.
What 8 FQHCs are participating?

- Brevard
- Charlotte
- Hillsborough (2)*
- Lee (3)*
- Manatee
- *Indicates different sites which may or may not be different FQHCs
- Your mission, should you choose to accept it, is to get your FQHC medical arm to provide this preventive service to pediatric patients! IF NOT- WHY NOT?
How well does the profession, both the academy and the practicing profession, protect the public?

Our educational policies related to students who act unethically.

ADA and CDE Codes related to dealing with the bad apples

How well do Licensing Boards really protect the public? They seem to have little appetite for peer review, only dealing with obvious problems, ie, drug use, rather than REAL censure of dentists providing poor care.
Many components of the dental profession are concerned about the “ethics” of the profession. (Welie, 2007)

- ACFD/AFDC 2003 congress on dental ethics
- ADEA/ACD/ADA Catalanotto/Patthoff conference on the ethics of access to care (2005)
- ADA/ACD Conference on Commercialism in Dentistry (2006)
- ADA 2007 Conference on ethics and integrity (2007)
- FDI new Dental Ethics Manual (2007)
- ADA resolution in 2000- getting rid of live patients in licensure examinations; initiated by SADA
- ADEA Deans Meeting, Fall, 2007, Barton Creek, Texas
WHAT KIND OF STUDENTS ARE WE RECRUITING?

• Despite considerable effort and good will, we are not recruiting a racially and ethnically diverse student body. We all know this data so I will not show it! Does this raise ethical concerns?

• We are also recruiting a socially and economically elite group of students— not at all reflective of the public they are to serve. Does this lead to ethical issues?

• Current students are very goal oriented, success driven and highly narcissistic! (& deeply in debt!)
“BABY BOOMERS” vs “CURRENT GENERATION”

“Our ethical map used to be clear, with the rules of good moral behavior more or less nonnegotiable. But all that has changed. Now....we are faced with a bewildering new ethical landscape, in which lying, cheating, and other forms of deception are commonplace in sports, business and politics- and in our personal lives. (AND I WOULD ASK- IN OUR PROFESSIONAL LIVES?)”

A. Allen, The New Ethics, A guided tour of the twenty-first century moral landscape, Miramax Books, 2004 HAS AN INTERESTING CHAPTER ON CHEATING
“Almost three-quarters of graduates in 2006 were from families with a combined parental income of more than $50,000.

Over 44 percent were from a family with a combined parental income of over $100,000, and nearly one in five graduates were from a family with an income of over $200,000.

As in prior years, in 2006 the percentage of graduates from families with higher incomes rose slightly.”
UFCD STUDENT FAMILY BACKGROUND
Class of 2007

- Neither parent completed college (20%)
- 1 parent completed college (17%)
- 2 parents completed college (15%)
- 1 parent completed some graduate work (25%)
- 2 parents completed some graduate work (22%)
- Approximately 30 have dentist/physician parents
UFCD FAMILY INCOME, Class of 2011
(1-5 are quintile rankings of 2006 US population; #6 is top 5% of families)*

- 1. Under $25,000 year (12%)
- 2. Under $45,000 year (12%)
- 3. Under $65,000 year (6%)
- 4. Under $103,000 (20%)
- 5. Under $184,000 (16%)
- 6. Over $184,000 (34%)

*from 59/83 student financial aid forms and an anonymous survey of 83 students
Rising narcissism and its implications for ethics education

Bebeau, 2007
Cross-temporal meta-analyses have shown a rise in individualistic traits on the Bem Sex Roles Inventory:
- independent, individualistic, leadership ability

Increasing scores on Rosenberg Self-Esteem Scale from 1960s → 1990s:
- self-esteem correlated with narcissism

MMPI: “I am an important person”
- 1950s: 12% agreement; late 1980s: 80% agreement

Recent cross-sectional study found younger people more narcissistic than older people:
- developmental changes or generational differences?

(Twenge, 1997; Twenge & Campbell, 2001; Newsom et al, 2003; Foster et al, 2003)
Narcissism increasing* Narcissism Personality Inventory (Raskin & Terry, 1988) Bebeau, 2007

average celebrity score, 2006

NPI scores increased .33 standard deviations from 1982-2006

Sara Konrath (2007)
So, based upon these student issues, are there potential ethical issues?

- How well with these graduates take care of all people, of all economic and racial groups?
- Is there evidence that racial and ethnic minority groups take “more” care of racial and ethnic minority patients? (Sullivan Commission).
- Does a diverse student body increase learning and understanding of these issues? (IOM)
- Should dental schools increase recruitment of ethnically racially diverse students?
- There are now DIVERSITY STANDARDS IN CODA
Is Dentistry a Profession?
Jos V.M. Welie

• Part 1. Professionalism Defined, J Canadian Dental Association, 70(8), Sept 2004, 529-532

• Part 2. Is Dentistry a Profession?, J Canadian Dental Association, 70(9), October, 2004, 599-602

• Part 3- Future Challenges, J Canadian Dental Association, 70(10), November, 2004, 675-678
SPECIFIC PROFESSIONAL RESPONSIBILITIES - Welie

• DETERMINING WHO CAN SERVE IN THE PROFESSION

• DETERMINING WHAT KINDS OF SERVICES ARE PROVIDED BY THE PROFESSION

• DETERMINING WHO IS SERVED BY THE PROFESSION
DETERMINING WHO CAN SERVE IN THE PROFESSION

- **Competence of Providers** - entry into dental school, completing dental school, maintaining skills after school.

- **Peer Review** - most patients do not know the quality of your work; the profession must assess itself.

- **Internal Discipline** - the profession’s profession to collectively foster the interests of patients, even if doing so entails harm to the self, demands internal disciplining.
Another Educational Ethical Elephant- letting out “impaired” graduates ultimately hurts the public!

Unprofessional behavior in medical school linked with disciplinary action by stage medical board. (Papadikis, et al., 2004; Stern, et al., 2005).

The same is probably true for dentistry BUT WE DO NOT HAVE ANY DATA!
Who serves, continued?

- **Peer Review** - Patients just don’t know so it is up to the profession to undertake such review.
- However, most dentists are sole proprietors, not sharing patients.
- Most dentists do not work in hospitals where there are formal peer review processes.
- Where dental peer review does exist (local dental societies) it is retroactive rather than proactive.
American Dental Association
Who serves, continued?

- **Internal Discipline** - ADA Code says a dentist must report a fellow dentist who appears to be harming patients but the threshold is much higher than CDA Code.

- **ADA Code** says only that “gross or continual faulty treatment” should be reported.

- **Advisory opinions** instruct dentists to abstain from unjustified criticism of colleagues and not make disparaging remarks about other dentists.

- **NO ADVICE IS GIVEN AS TO WHEN AND HOW BEST TO REPORT FAULTY TREATMENT!**
Canadian Dental Association Code of Ethics

• **Article 2: Inappropriate Conduct** - A dentist has an obligation to report to the appropriate review body, unprofessional conduct or failure to provide treatment in accordance with currently accepted professional standards.

• **Article 2: Judgments in Peer Relations** - A dentist should not make disparaging comments of the procedures or qualifications of a colleague to a patient or the public. In the interest of the public, dentists are encouraged to consult with a previous dentist, concerning treatment rendered. Through discussion, it should be possible to advise a patient how to achieve an appropriate resolution.
Examples of concerns about the practicing profession

- Old Reader’s Digest article (Ecembarger, How dentists rip us off. How Honest are Dentists? *Readers Digest, February 1997:50-56*)


- Newest Christensen editorial, most recent JADA- this recession is good for patients October?)

- Recent NPR piece about irrational relationship between patients and their dentists
What kind of service is provided? Welie

• **Services that are beneficial by Objective Standards** - Subjective decisions about care don’t meet this obligation. Empirical science, statistical analyses & outcomes research attain objectivity.

• **Standardization of Treatment** - Calls for the development of TX protocols that result in effective and efficient treatment; evidence based care.
What kind of service is provided?

- Professionals are expected to provide treatments that, by objective standards, are in the interests of those served.

- However, there is so much variation in treatment that the public has come to believe they are being ripped off by dentists. (Ecembarger, How dentists rip us off. How Honest are Dentists? Readers Digest, February 1997:50-56)
Gordon Christensen’s thoughts on why dentistry has changed

- “having a **commercial**, self-promotional orientation”
- “planning and carrying out **excessive** treatment”
- “charging **high fees** without justification”
- “providing services only when it is convenient”
- “refusing to accept responsibility when treatment fails prematurely”

Rule and Veatch, Ethical Questions in Dentistry, 2004, p 7
Who is served? Welie

• **Fostering Access** - To the extent that factors restricting access are caused by the profession itself, the profession is responsible and must strive to end them.
Who is being served? Welie

- **ADA Code** emphasizes dentists’ right to choose who they treat but Welie thinks this raises questions about professions commitment to social contract.
- Many dentists claim the right to choose their patients and dismiss noncompliant patients.
- Many dentists provide charitable care to indigent/underserved patients - is it enough?
- Welie raises the issue of not enough dentists with specialized expertise to treat certain kinds of patients.
- And if dentistry is beyond the financial means of many people, is the social contract violated?
The talked about access issue

- 2000 Surgeon General’s Report- The poor, children, aged, rural, minority populations
- Inadequate Medicaid fees
- Lack of dental insurance
- Size, distribution and makeup of the oral health workforce
- We all know this data and some of us talk about it all the time! BUT, WHAT IS BEING DONE?
Beyond the financial means of many people, approaching the middle class!

- Data supplied by Dr. Linda Johnson- Palm Coast, Florida.
- 2005 Median Family Income $46,326
- Exam, X-Rays and 1 crown = $1500; This is a minimal need in her practice.
- That is 3.2% of Median Family Income
- For a family of four needing this care, 12.8% of family income.
- So, is this a matter of prioritizing family expenditures, is this a matter of health, can the average family afford dental care?
ACCESS - community/public and academic workforce - how many warnings do we need?

- Bottom line to me and others - access is ultimately an ETHICS issue - Catalanotto, Patthoff and Gray, Professional Promises, J Dent Educ, Nov, 2006
- “The shortfall in health care cannot be resolved in the marketplace alone. It is time for organized action.”

Senior Survey Data - a source of optimism

- "ensuring and providing care to all segments of society is an ethical and professional obligation"; Over 15 percent of respondents disagreed or strongly disagreed, a decrease from 18% the previous year.

- "everyone is entitled to receive basic oral health care regardless of ability to pay." Approximately 22 percent of all disagreed or strongly disagreed, a substantial decline from 27.5 percent in 2005.
Health care reform - what is in there for oral health?

• Adapted from a brief put out by the PEW Children’s Dental Campaign, Shelly Gehshan, Director

• And from a presentation to the ADEA Legislative Action Committee by Jack Bresch
Opposition to health care reform

Dr. Cadle said “The big question will be whether or not dentistry will be included in universal health coverage...? We should position dentistry to be excluded.”

“I think that Dr. Cadle’s position is a correct one if one considers access to dental care to be a commodity to be bought in the open supply and demand business market. We all recognize that running a dental practice is a business with significant investments of education, time, personnel and physical plant that must operate in the black. However, we also need to remember that oral health is clearly related to overall health and the evidence for that linkage is increasing every day. Thus, oral health care is not a commodity but rather an integral part of a person’s well-being. As such, if we provide a health care system for our nation’s people that includes universal health coverage, then we must include access to dental care in that coverage. Otherwise, we are abrogating our moral responsibilities to our patients as their oral health care professionals.”
Coverage

• Guarantees oral health services for children up to 21
  ✓ HHS essential health benefits package must include oral pediatric services

• Expands Medicaid eligibility for adults and children
  ✓ 133% of Federal Poverty Level (FPL) (but states can decide)

• Extends Children’s Health Insurance Program (CHIP)
  ✓ Through September 30, 2015

• Increases federal support to states to pay for expanded Medicaid coverage
Goal- Expand the number of professionals who can provide dental care to low-income children

• Authorize a demonstration program for new/alternative models of care (including community dental health coordinators, advanced practice dental hygienists, independent and supervised dental hygienists, primary care physicians, dental therapists, dental health aides) funded by fifteen five year grants of at least $4M each. Only pilot programs authorized by state law can be funded. Contract with IOM to study results.

• Allow expansion of DHAT model for tribal lands.

• Increase funds for CDC grants
Goal - expand sealant programs for kids who need them most

- Expands School-Based sealant programs
Goal- Help expand access to optimally fluoridated water

• Increase community understanding of water fluoridation and other preventive activities.
Additional Provisions related to Children’s oral health

• Monitors trends in oral health
• Support for school-based health centers
• Funds for provider training for dental and allied dental and advanced education programs
• Primary care residency training
• Funds for Community Health Centers – expansion of dental programs.
National Health Care Workforce Commission

- Establishes National Health Care Workforce Commission

- Overall goal: To provide comprehensive, unbiased information to Congress and Administration on how to align federal workforce resources with national needs

- Congress will use information when appropriating funds for discretionary programs
Oral Health Prevention

- Establishes five-year national, public education campaign focused on oral health care prevention and education (HHS/CDC)
  - Target: children, pregnant women, elderly, individuals with disabilities, ethnic and racial minorities

- Provides grants to all 50 states, territories, Indian tribes, tribal organizations to:
  - Develop oral health leadership
  - Build oral health data systems
  - Implement dental sealants, water fluoridation, and other prevention programs

- Provides grants to demonstrate the effectiveness of research-based dental caries disease management activities
National Health Services Corps

- Extends program through 2015

- Increases funding
  ✓ $320 million for FY 2010 - $1.2 billion for FY 2015

- Allows for half-time services and teaching to count for up to 20% of service commitment

- Increases annual loan repayment award maximum from $35k to $50k
Medicaid/CHIP Commission

- Establishes Medicaid and Children’s Health Insurance Program Payment and Access Commission (MACPAC)

  ✓ Topics to be reviewed by MACPAC include assessment of adult services in Medicaid, payments for dental services, and process for updating payments to dental health professionals

  ✓ MACPAC membership includes dentists

  ✓ Authorizes $11 million for FY 2012
THANKS FOR THE OPPORTUNITY TO BE HERE

QUESTIONS??

GO GATORS
WAIT UNTIL NEXT YEAR