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AGEISM IN HEALTH CARE: ARE OUR NATION'S SENIORS RECEIVING PROPER ORAL HEALTH CARE?

FORUM

BEFORE THE

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FORUM ON AGEISM IN HEALTH CARE: ARE OUR NATION'S SENIORS RECEIVING PROPER ORAL HEALTH CARE?

MONDAY, SEPTEMBER 22, 2003

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Forum convened, pursuant to notice, at 2:05 p.m., in room SD–628, Dirksen Senate Office Building, Hon. John Breaux, presiding.

Present: Senator Breaux.

OPENING STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. If everybody would please find a seat, we can begin our afternoon session, and I will do so by welcoming everyone to what is really a forum this afternoon; it is not a formal Aging Committee hearing, but it is an opportunity for all of us who are interested in the question of health care for our Nation's seniors to focus in on one particular aspect of our Nation's health concerns and particularly dealing with our Nation's older Americans, and that is the whole question of proper oral health care, dental care, for our Nation's senior citizens.

So I would like to welcome everyone to this session this afternoon, and I want to thank the Chairman of the Aging Committee, Senator Craig, for his cooperation and support and assistance for allowing us to meet and have this discussion.

This afternoon we will focus on the question of whether older Americans are receiving proper oral health care. I think the purpose is really threefold—first, to define the oral health issues that are facing our Nation's seniors today, and second, to try to develop and discuss some potential solutions to the problems that exist; and third, to alert Americans about the opportunities they have to help improve health care, particularly oral health care, for America's elderly.

Although there have clearly been dramatic improvements in oral health care during the last 50 years, profound disparities continue to exist for those without the knowledge, the resources, or the capability to achieve good-quality oral health care.

This certainly includes our poor and vulnerable elderly and disabled adults, and poor oral health care causes suffering to millions of Americans and obviously particularly to our most vulnerable population.

Twenty-three percent of the 65- to 74-year-olds have severe periodontal or gum disease. The percentage of risk increases, of course, as people age. People at the lowest socioeconomic levels have even more severe periodontal disease. Oral and pharyngeal cancers are diagnosed in about 30,000 Americans annually, and 8,000 die from these diseases every year, which are primarily diagnosed in the elderly, and their prognosis is very poor.

Fewer than 2 out of every 10 older Americans are covered by private dental insurance. Uninsured Americans with severe oral disease often end up in hospital emergency rooms, where the problem is addressed with painkillers and/or tooth extractions, both of which are obviously only a temporary fix, wasting millions of taxpayer dollars every year.

Recent research has further highlighted the results of poor oral health care. Studies have shown a connection between chronic oral infections and heart and lung disease and stroke and diabetes and premature birth. Infections resulting from oral infections place individuals at serious risk of death. Infectious diseases of the mouth left untreated can cause undue pain and suffering and poor quality of life, and even death.

Clearly, all Americans need to be aware of the need for good oral health. However, our emphasis today is on grappling with how best to ensure that our older Americans receive proper oral health care. It is my hope that this forum will accentuate the importance of oral health.

Thanks to the generous support of Oral Health America, we are releasing a report today entitled "A State of Decay: Oral Health of Older Americans." As you can see from the charts behind me, Oral Health America surveyed all 50 States and the District of Columbia on the extent of the oral health care services for Medicaid adults. As a part of this study, a report card was developed that reflects predominantly failing grades in all jurisdictions, giving the United States a score of "D" as our national average. It is very alarming, considering the severe health consequences and resulting cost of poor oral health care.

I thank each and every one of you for being with us and for your participation and look forward to hearing from you as we discuss this issue.

I would first like to welcome the Surgeon General, who is a surgeon but not a general, but he is an admiral, and we are very pleased to welcome Vice Admiral Richard Carmona, who is our Surgeon General. Vice Admiral Carmona was sworn in as the 17th Surgeon General of the United States Public Health Service in August 2002. He is a decorated veteran and graduate of the University of California Medical School. Dr. Carmona has published extensively and received numerous awards, decorations, and local and national recognition for his achievements. We thank him for participating and for his support.

I would also like to introduce Dr. Greg Folse, who is a practicing dentist from Lafayette, in my State of Louisiana. He was instrumental in drawing my attention in the beginning to the critical issues surrounding oral health of the elderly. He has a mobile geriatric dental practice and also works with the American Dental Association and Special Care Dentistry to improve oral access for

special needs patients. He is really very passionate about caring for the oral health of the elderly and carries out that mission every day of his life.

I have seen the slide presentation that Greg will make to us this afternoon. It is most impressive in highlighting the serious nature of the problem that we face as a Nation.

I would also like to say thanks to all of the organizations represented here this afternoon. I am pleased to introduce these organizations and the representatives who are here today. Your biographies are all included in our official record, and I will simply recognize you for the sake of brevity:

From the Alliance for Aging Research, Dan Perry. Dan, thank you for being with us; from the American Association for Dental Research, Dr. Robert Collins; from the American Association of Public Health Dentistry, Dr. Teresa Dolan; from the American Dental Association, Dr. James Harrell; from the American Dental Education Association, Dr. Paula Friedman; from the American Dental Hygienists' Association, Karen Sealander; from the American Health Care Association, Dr. Jonathan Musher; the CMMS-HHS chief dental officer, Dr. Conan Davis; from Louisiana State Dental Medicaid Services, Dr. Robert Barsley; from Oral Health America—thank you for the good work—Dr. Robert Klaus; from Special Care Dentistry, Dr. Paul Glassman.

Thank you all.

I would like to also introduce Janet Heinrich, who is with GAO, the Government Accounting Office's Director of Health Care and Public Health Issues. She has put together and led many of the health studies that we have utilized, both in the Finance Committee and in our committee on elderly issues, for the U.S. Senate and for the Congress, and we appreciate once again her doing the work. We are going to ask her to moderate if I have to leave some of the discussion, Janet, if that would be all right with you.

Ms. HEINRICH. Yes.

Senator BREAUX. Our format will be to first hear from our Surgeon General, Dr. Carmona. If you would go ahead and lead us off, we would appreciate hearing from you, and then we will go to Dr. Folse and his slide presentation.

Mr. Surgeon General, we are delighted to have you with us.

STATEMENT OF VICE ADMIRAL RICHARD H. CARMONA, SURGEON GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. CARMONA. Thank you, Senator. It is nice to be here. Thank you for taking the leadership in this very important area.

My name is Richard Carmona. I am the United States Surgeon General, and as an American, I want to take this opportunity to thank all of you for the service that you have provided to the Nation in keeping this very important issue on the forefront.

I have had the honor of working with many of you during my first year as Surgeon General and look forward to strengthening our partnerships to improve the health and well-being of all Americans.

Senator, you have been a leader in addressing the health needs of America in general and its seniors, and I thank you so much for

continuing to take the lead in those issues. It was a pleasure participating with Senator Craig, another leader, just recently in a Montana Health Summit, and Senator Burns, who also understand the value of public health and keeping our citizens healthy.

Today I welcome the opportunity to talk with this committee about the oral health of America's seniors. While oral health is tremendously important, I am sure I do not have to tell you that it does not receive much attention. For that reason, I appreciate the focus of this forum, especially in the context of a holistic approach to disease prevention.

Poor oral health adversely affects all aspects of life. Kids cannot learn in school if they are in pain. Adults miss work due to dental pain and tooth and gum decay. Twenty-two percent of adults report having some oral pain in the past 6 months. Oral and pharyngeal cancers, primarily found in the elderly, are diagnosed in about 30,000 Americans annually. Tragically, 8,000 Americans die from these diseases each year.

"Oral Health in America," a report of the Surgeon General, recognizes that such oral health is essential to general well-being and that the oral health of America's seniors is today an acute problem. The facts are staggering. About 30 percent of individuals 65 years and older have lost all their teeth. The rate of oral and pharyngeal cancers is higher among seniors than for any other age group. Americans 65 years and older are seven times more likely to be diagnosed with oral cancer than younger individuals.

The vast majority of payment for dental services is out-of-pocket for older people, with only rare exceptions. Medicare does not cover the cost of oral health services. This results in compromised access for our seniors. While 61 percent of the general population reports having a dental visit in the past year, only 45 percent of seniors 75 years and older report seeing a dental professional in that same time period.

A number of HHS programs focus on oral health needs of seniors. HRSA's oral health program is increasing access to oral health care through its 843 health center grantees. Seventy-two percent of these centers offer preventive dental care. Also, NIH's National Institute of Dental Health of Dental and Craniofacial Research reports many clinical trials related to the oral health of seniors.

In addition, CDC's division of oral health supports oral health projects in predominantly poor, ethnically diverse communities. These projects include: mobilizing community health workers to improve oral health practices in rural Alabama; setting up an oral health training program for nurses who care for homebound seniors in Harlem, which is my old neighborhood; and in Washington State, training seniors to be oral health educators for children, which improves the health of the kids and the seniors.

As you know, in April of this year, I released a National Call to Action to Promote Oral Health. The Call to Action is a guide for our efforts to improve oral health. It outlines five action areas.

First, we need to change the perceptions of oral health. We can no longer afford to have Americans believe that oral health is separate from general health and well-being. Improving health literacy is key to improving America's oral health.

Second is to replicate effective programs and proven efforts. Best practices in oral health must be recognized and replicated in every State.

Third is to build the science base. Biomedical and behavioral research is transforming our knowledge of prevention, diagnosis, and treatment of oral diseases. This knowledge must be turned into action.

Fourth is to increase oral health workforce diversity, capacity, and flexibility. Women and minorities are under represented in the dental profession. We must encourage diversity and use culturally competent messages to eliminate disparities in oral health.

Fifth and finally is to increase collaborations. Disease prevention and health promotion campaigns that affect oral health, such as proper brushing and flossing and regular checkups, as well as tobacco control and nutrition counseling, can lead to improved oral health for all Americans.

The prevention message that President Bush, Secretary Thompson and I have been emphasizing is applicable to ensuring good oral health. For example, there are simple steps that any person can take to prevent dental diseases. They are: proper brushing and flossing; use of fluoride rinse or toothpaste; regular visits to the dentist; healthy eating; limiting alcohol use and avoiding tobacco.

In particular, tobacco use, whether cigarettes, cigar, or smokeless tobacco, frequently results in oral cancers. Most people, even many health professionals, do not know that smoking causes over 50 percent of the periodontal disease in the United States.

We need to get this information to the public and to health professionals. Again, it is an issue of health literacy. It is a battle in many areas of public health that I find, increasing health literacy so that people understand the good science that we have already available and we are not using it fully.

In closing, I will add that today must be a day of change. Today must be a day when our work is a catalyst for better oral health. I thank you for many efforts on behalf of seniors, and I promise to work with you to improve the health and well-being of all Americans.

With that, I will end my oral remarks. I would ask to be able to submit my entire written statement into the record, and I would also be happy to answer any questions, Senator.

Thank you very much.

Senator BREAUX. Thank you, Dr. Carmona.

I understand that you need to catch a plane, so we are not going to keep you too long. I am going to let you be excused whenever you feel that you have to.

Dr. CARMONA. Thank you, sir.

Senator BREAUX. But I want to thank you for your participation. I think that a lot of people do not understand the serious nature of the problem, and I think that you as the Surgeon General obviously have the capacity to highlight the serious nature of oral health care for seniors at a time when many Americans seem to be more concerned about the color of their teeth; they want to make them whiter, and there are more and more products for whiter teeth and how you can get them to be brighter and brighter. There are many older Americans who are suffering very severe

health problems, not because of lack of white teeth but because of severe infections and other problems that they have.

So in your capacity as Surgeon General, I think it is important that you make the statement that you made today and continue to try to highlight this as a particular problem and a particular concern.

So we thank you for being with us and hope you can continue helping to educate the American public about this very serious problem.

You may be excused whenever you have to go because you have told me that you need to catch a plane for a trip.

Dr. CARMONA. Thank you, Senator.

I would just add that, as I said when we released the report, you have my full commitment as does the American public in keeping this area of oral health on the forefront.

Thank you, sir.

Senator BREAUX. Thank you, Admiral.

[The prepared statement of Dr. Carmona follows:]

Remarks
Before the Special Committee on Aging
United States Senate

"Ageism in Healthcare: Are Our Nation's Seniors Receiving Proper Oral Health Care?"

Statement of
Richard H. Carmona, M.D., M.P.H., F.A.C.S.
Surgeon General
U.S. Public Health Service
Department of Health and Human Services

For Release on Delivery
Expected at 2:00 PM
on Monday, September 22, 2003

Good afternoon Mr. Chairman and distinguished members of the Committee. My name is Dr. Richard Carmona, and I am the Surgeon General of the United States.

As an American, I want to take this opportunity to thank you for your service to our nation. I've had the honor of working with many of you during my first year as Surgeon General, and I look forward to strengthening our partnerships to improve the health and well-being of all Americans.

When I speak to people all over America, I tell them "we can't go it alone." As Secretary Thompson says, "we have to get out of our silos and sectors and work together."

It takes partnerships to solve public health problems. That is certainly the case for disease prevention, emergency preparedness, and eliminating health disparities, all priorities on which President Bush and Secretary Thompson have asked me to focus. It is also the case for making sure that we maintain and improve our oral health.

The burden of oral infections and conditions that affect the mouth, face and jaw are so broad and extensive that the dentists can't do it alone; the hygienists can't do it alone; surgeons can't do it alone; educators can't do it alone; government can't do it alone. It will take all of us working together to continue to make progress in advancing the oral health of all Americans.

Today, more than 75% of our health care dollars are spent on chronic diseases and conditions that are largely preventable — diabetes, obesity, heart disease, stroke, and cancer.

We are a treatment-oriented society. We wait for people to get sick and then we spend top dollar to make them healthy again.

We need your help to bridge the cultural divide ... from a treatment-oriented society to one that is prevention oriented. My purpose here today is to encourage each of you to determine what you can do to promote oral health and prevent oral disease.

While oral health is tremendously important to all Americans, I'm sure I don't have to tell you that it is not always the focus of much attention. Americans tend to think that oral health is less important than, and separate from, general health.

But we must remember that the mouth is essential for so many of the day's activities, like talking, eating and breathing. I sincerely appreciate the focus of this forum today, especially in the context of a holistic prevention approach. Let's face it, prevention starts with the head.

Studies tell us that toothache and craniofacial disorders are common among American adults. Twenty-two (22%) percent of adults in our nation reported some form of oral-

facial pain in the past six months. And oral and pharyngeal cancers, primarily found in the elderly, are diagnosed in about 30,000 Americans annually. Eight-thousand (8,000) people die from these diseases each year.

Poor oral health adversely affects all aspects of life. Kids can't learn in school if they are in pain. Adults lose work hours due to dental pain and tooth and gum decay.

The findings of the science-based report, Oral Health in America: A Report of the Surgeon General recognized that oral health is essential to general health and well-being. This integral relationship is demonstrated by the fact that oral diseases in and of themselves affect health throughout life and that general health problems, such as diabetes, osteoporosis, HIV, and other conditions, are associated with oral manifestations and effects. In addition, this report highlights the fact that low-income individuals have a higher prevalence of untreated oral diseases regardless of age.

Seniors, by the nature of their life span, are more prone to chronic, disabling diseases and conditions; are more apt to be on regimens of daily medications; and have a greater likelihood to be low-income than other adults. These factors and others have a profound affect on their oral health.

The data supports and re-enforces the need for your attention to the oral health of seniors:

- Periodontal infections are more common in the elderly; about 23% of 65-74 year olds have several periodontal diseases;

- About 30% of individuals 65 and older have lost all their teeth. However, statistics vary by state.

- Studies have shown possible association between oral infections and systemic diseases such as diabetes, heart disease, and respiratory infections.

- The incidence rate of oral and pharyngeal cancers is higher among seniors than for other age groups. Seniors who are 65 years and older are seven times more likely to be diagnosed with oral cancer than younger individuals.

- Many seniors take medications that have the complicating side effect of reducing salivary flow (the amount and flow of saliva) resulting in xerostomia (or "dry mouth"). Reduction in salivary flow contributes to increased dental decay.

- The vast majority of payment for dental services is out-of-pocket for older people. Medicare does not cover cost for oral health services and dental

care, with only rare exceptions. For most people who have dental insurance coverage as a benefit of their employment, that coverage ends upon their retirement.

- In addition, most seniors have limited income. This results in compromised access to dental care. Seniors are less likely to report having a dental visit in the past year. While 61% of the population reports having a dental visit in the past year; only 45% of seniors 75 years and older report having a dental visit.

- Nursing homes and other long-term care facilities have limited capacity to deliver needed oral health services to their residents, most of whom are at increased risk for oral diseases.

In April, I released A National Call to Action to Promote Oral Health. This Call to Action was the result of a public-private partnership under the leadership of the Office of the Surgeon General that identified key actions that should be undertaken to improve our nation's oral health. As I noted in the Call to Action, "It is abundantly clear that these are not tasks that can be accomplished by any single agency, be it the federal government, state health agencies, or private organizations."

Changing perceptions of the public, health care providers, and others about oral health

and its implications is one of the key actions. Some examples of steps that need to be taken include enhancing health literacy of our population, including oral health literacy; promoting interdisciplinary training of health professionals in counseling patients about how to reduce risk factors common to oral and general health; and training health care providers to conduct oral screenings as part of routine physical examinations and, when necessary, to make appropriate referrals.

Overcoming barriers to care by replicating effective programs is another important action step for improving the oral health of America's seniors. For example, HRSA's Bureau of Primary Health Care's Oral Health Program is specifically oriented to increasing access to oral health services. These programs support an oral health safety net for under-served populations, including the aging population. At this time there are 843 health center program grantees. 72% of the health centers provide preventive dental care onsite or by referral.

As always, building the science base is needed. CDC's Division of Oral Health provides substantial support for projects that examine the effectiveness of innovative strategies to promote oral health in predominately poor, ethnically diverse communities. Consistent with findings of recent reviews by the Task Force on Community Preventive Services and issues that I, as the Surgeon General, have raised, these projects are designed to address environments and behavior at multiple levels.

Projects that focus on older adults include: mobilizing community health advisors and changing care seeking behavior and oral health knowledge, attitudes and practices in rural Alabama (University of Alabama at Birmingham Center for Health Promotion); design, implementation, and evaluation of an oral health training program for nurses and home attendants caring for homebound elderly persons in Harlem (Columbia University Harlem Center for Health Promotion); and training elderly persons as oral health educators for children, an approach that could improve oral health among both age groups (University of Washington at Seattle Health Promotion Research Center).

In addition, NIH's National Institute of Dental and Craniofacial Research emphasizes the need to address health needs of the elderly. An ongoing clinical trial is looking at how multiple interventions can enhance oral health in the elderly (University of Washington). The purpose of this study is to test the effectiveness of a simple, low-cost intervention to reduce tooth loss in adults with a history of infrequent oral health care.

Finally, since oral health conditions are chronic and cumulative, investments in community-based, professional, and individual strategies to promote oral health across the lifespan will be of major benefit to improved oral health in the senior years.

In closing, let me summarize the goals of the National Call to Action to Promote Oral Health. They are:

- To promote oral health;
- To improve quality of life; and
- To eliminate oral health disparities.

Sounds simple enough, but how do we get there? To begin, it will be up to those of you in this room to help make oral health care a part of health policy agendas. We must first educate the public, health professionals, and policymakers about the importance of oral health to general health and well-being at every stage of life. In addition, the oral health community must act to address the nation's overall health agenda.

The National Call to Action can be considered a "road map for oral health" — a guide for our efforts to improve oral health. The Call to Action asks for your response in 5 Action Areas:

1. Change Perceptions of Oral Health. We can no longer afford to have Americans believe oral health is separate from their general well-being. Improving the health literacy of the public, including oral health literacy, is key. Ensuring that other health professionals are knowledgeable about oral health is also important so that they can identify when a patient needs specific education or treatment related to oral health.

2. Replicate Effective Programs and Proven Efforts. As I've mentioned, many states have innovative programs through HRSA and under the research projects funded by NIH. The best practices must be recognized and replicated to help all seniors, in every state.

3. Build the Science Base. Biomedical and behavioral research will transform our knowledge of the prevention, diagnosis, and treatment of oral disease. But this knowledge must rapidly be turned into action for the public, providers, and community programs. We must ensure that the new science benefits all consumers, especially those who are in poorest oral health or at greatest risk.

4. Increase Oral Health Workforce Diversity, Capacity, and Flexibility. Women and minorities are underrepresented in the oral health professions, especially African Americans, Hispanics, and Native Americans. We should encourage diversity within the dental profession and culturally-competent messages as part of our effort to eliminate disparities.

5. Increase Collaborations. Disease prevention and health promotion campaigns that affect oral health — such as proper brushing and flossing and regular check-ups, as well as tobacco control and nutrition counseling — can lead to overall improved oral health for all Americans.

It is also important to remember that the *prevention* message that President Bush, Secretary Thompson, and I have been emphasizing all over America is as applicable for ensuring oral health as it is for avoiding other chronic conditions.

There are simple, small steps that any person can take can prevent dental diseases and improve their oral health:

- Proper brushing and flossing;
- Use of fluoride rinse or toothpaste;
- Regular visits to the dentist;
- Healthy eating;
- Limiting alcohol use; and
- Avoiding tobacco.

Tobacco use — whether cigarette, cigar, or smokeless tobacco — can cause various forms of oral cancer. Less well known by the public, and even by many health professionals, is that cigarette smoking is responsible for half the cases of periodontal disease in the United States.

We need to get this information out to the public and to health professionals. Think of the many perspectives we have right here in this room, and the tremendous opportunity those perspectives represent for carrying the prevention message on oral health to every man, woman, and child in America.

As our elected leaders, you can help shape the debate on various levels to ensure that the oral health prevention perspective is heard. We are at a point in our nation's health history when we can really make a difference. Each and every one of us has the duty and responsibility to use the tools at our disposal to effect positive change. This change can come at the national level, it can come at the state level, it can come at the community level, and it can come in our own homes.

Today must be a day of change. Today must be a day when our work is a catalyst for better oral health for all Americans who need it. I thank you for your many efforts on behalf of senior's health, and I promise to work with you to improve the health and well-being of all Americans.

Thank you for your time, and for inviting me here today.

Senator BREAUX. Now let us ask Greg to make his slide presentation, and then we will be able to begin the dialog that I hope we can get on trying to find out what we need to be doing.

Dr. Folse.

STATEMENT OF GREG J. FOLSE, LAFAYETTE, LA

Dr. FOLSE. I want to thank you very much, Senator Breaux, for bringing us all together today.

You talked about the whitening—I think the color that my patients would really like to have their teeth is "some." Unfortunately, that is where we are.

That is one of the things that Louisiana happens to do well, actually. We have a good denture program for our elderly, but we do not pay for a lot of other things.

I also want to thank Dr. Carmona in his absence for his call to action. I think it is already affecting lives. But we have a long way to go.

Ageism and oral health—are our Nation's seniors receiving proper oral health care? The answer is resoundingly no—they are not receiving it right now when you look across the board.

The Surgeon General's report in 2000 called it "a silent epidemic" for our elderly. I think that when you really look at it, and you see the patients that I see—and let me back up a little bit. I have a mobile geriatric practice, and I go to nursing homes every day; I am in there day in and day out. When you see what I see, it is not silent—it screams. It screams for us to take action on the issue.

This is Miss Sylvia. I am going to introduce you today to a few patients of mine, and if you cannot see, please get up and move around; that is fine with me. Ms. Sylvia was the mother of a nursing home administrator. She had just arrived at the facility. She was poor. She had been in the community. You will notice her hair is pretty; she has it all combed. She was really trying to take care of herself. She has lipstick and rouge, and everything was Cadillacing for her—except when you looked in her mouth.

She did not have access to oral health services. She did not go and have her teeth cleaned. She had gum disease. She had broken teeth. She had abscesses in the back of her mouth. She had infection.

We cannot stand for this. Her daughter cared dearly for her and did not really realize that this was going on.

This is Mr. Joe, an old man in a facility—I work in facilities all day, and I love nursing facilities. It is not that he was there, but there is a great burden of disease when these patients get into nursing facilities, and that burden is difficult for us to deal with.

He had a tooth, which you can see right her, that they asked me to take a look at. When I did, they told me his story. He was a grumpy guy who would sit in his wheelchair and literally run the wheelchair into your ankles. He was ornery and hated everybody, and nobody liked him.

Well, when I looked in his mouth, under his lip was this huge squamous cell carcinoma. This guy thought he was dying; his face was rotting off. This cannot be. Had he had one dental evaluation, one cleaning, while he was getting older, someone would have picked this up.

We did radiation therapy, this became a little scar, and the guy did very well. He started going to bingo and became a good part of the facility.

Who are these patients? When I look at the country, I had this term introduced to me not too long ago—the "aged, blind, and disabled." If we can think about our seniors and our vulnerable adult population and use this term, we will be ahead of the game, because this term is defined in Social Security law, so it is a great place to hang our access hat.

This gentleman, Mr. Charles, is a good representative of "aged, blind, and disabled." He is all three of them. He was in a facility, and I told him 2 months ago, "I am going to Washington. I am going to try to get some help for your teeth." He was all happy, and he gave me this kind of convoluted smile that you can see here. He was happy about it.

He allowed me to take photographs of his mouth, and today he sits in this facility with no access to oral health care with these teeth. This is how he eats every day. He has broken teeth, he has gum disease, he has abscesses. These are teeth that are broken off at the gum line, for those of you who do not know.

When I told him that I was going to Washington just to talk, he thought I was going to take his teeth out that day, and he got angry; and when he did, this was the face he made, and I just quickly took a shot of it. I am with you, Mr. Charles; I feel the same way. Let us do something.

How many of them are there? In my written testimony, I have some actual numbers of disabled adults, but we all know that the number of seniors in our country is going through the roof.

Just like Miss Marsha—these slides I took a month ago—6 months ago, she had an abscess for this little tooth, right here. This tooth needed extraction 6 months ago. There is no access in our State, along with other States—I will tell you how many in a little while. I put her on antibiotics. Someone else put her on antibiotics a month later, and someone else again a month after that.

A $100 extraction would have taken care of this. The fourth time she got infected, she got an MRSA infection, which is a staph infection that is resistant to antibiotics. She had to go in the hospital—and that is where these pictures were taken—so that they could do a little surgical procedure, a drainage here. During the procedure, she was septic, and her heart stopped beating, so she went into the ICU for 4 days. One hundred dollars for an extraction, $30,000 for a surgery and ICU stay. It does not make a lot of sense, besides the suffering that this lady had to go through.

As a practitioner, it kills me, because they sit and they rot under my care, and I hate it. Guys like me all across the country see the oral health of our seniors is neglected.

The report from the Surgeon General said there are many disparities, and there are. The elderly take the brunt of it. If you have money, you can get care—until you get medically or functionally disabled, or until you get institutionalized or you spend all of your money. Then you start losing that access that we all have as functional adults.

Within the "age, blind, and disabled"—and I realize this is not quite as on-point—but we have mentally retarded adults in our

country who sit in facilities or who sit at home with no access to oral health care. This is a sin that our mentally retarded do not have access.

This poor gentleman sits—he is losing his teeth, he has gum disease, he has abscesses—and there is nothing I can do about it. There are hundreds and thousands of them across the country like this. We have to do something on a national level.

I wish the Surgeon General was here for this. We need a statement from him saying that oral health services are medically necessary for this vulnerable population. I think that is going to be a key to the advocacy or the push to get services.

It goes on and on, people. I saw this guy, and 2 years before I took this photograph, these four teeth were in perfect shape; he had a $900 partial hooked to it that he was eating with. Two years later, after a stroke, he has gum disease, he bleeds every time he eats—and no access to care.

This is the old tooth in the lung, another $100 extraction that turned into a $40,000 or $50,000 surgical procedure and hospital stay with all these complications. A loose tooth—she rolled over, hit her mouth on the bed rail, and it went into her lung.

This is a birth mark. Miss Mary had this birth mark all her life. But what I want you to look at are her eyes. Do you see that? Two weeks before I took these photographs, Miss Mary was walking and talking. She developed a dental abscess. Had she had any access over the last few years of her life, they would have caught something.

Miss Mary, you can see, is swollen here; actually, she has some purulent drainage down on her bib. This was in the front of her mouth. I would think that this tumor would have been caught by somebody had we had access to oral health for an aged, blind, and disabled adult. She could have gone somewhere.

Miss Mary died from the infection that got into this tumor. They could not take care of it. Seven days after I took these photographs, she passed away and really has solidly put the need for what we are doing here today in me.

My wife will kill me, but I offer my services to all of you as we go through this process of getting access for these patients to help in any way I can.

What benefits are available? The Surgeon General talked about it. There is virtually nothing until you get down to Medicaid—virtually no Medicare, private insurance, applied income laws. Medicaid has optional programs for every State. States can individually choose whether they want dental services or not.

This is what our country looks like—blue is a B; New York gets a B—as far as Medicaid services go. The green States are C's. The yellow States are D's, and the red States are F's. I got to pick the colors, too—it is pus yellow and blood red—and I am not going to apologize for it. It is a sin.

We have 45 States with a D or an F, and when you look at the service reimbursements—and all of this is included in the Oral Health Report Card from Oral Health America, which I thank you guys for doing; it was great to be a part of that—when you look at the service reimbursements for the providers out there, all States except one get a D or an F.

So when I couple the D-minus grade for Medicaid with the vulnerability of the "aged, blind, and disabled," I give our country an F on how we are doing.

Do we get it yet? There is nothing out there for these adults. The system of optional Medicaid oral health benefits is not working. We have in essence designated treatment of pain, pus, infection, and swelling as "optional," and it does not make sense, and I know you all agree with me.

So nationally, unfortunately, we have no infrastructure for oral health for "aged, blind, and disabled." We do, however, have an infrastructure for children under EPSDT, and this is where I really think the solution can come. I believe that if we could take the "aged, blind, and disabled" who are already approved for Medicaid and put them into coverage under EPSDT or in a system like that, I really believe that that would work.

National solutions—again, we need a bill, and I know that you will be open to helping us with that with the ABD patients. Within my testimony, I have included kind of the guts of that idea of the "aged, blind, and disabled oral health access proposal"; it is in my written testimony. I would love to see a declaration that oral health services are definitely medically necessary. I would like to see the formation of a National Oral Health Coalition for Special Needs Adults, and a dental director in every nursing home.

It can be done well. This is Miss Daisy. I made these dentures for her when she was 103 years old. Miss Daisy lost them 4 years later, and I remade them. Miss Daisy wore those dentures until she was 112 before she passed away. She had good oral health, and it meant a lot to her. We can do that on a national level.

I thank you all very much for being here, and I thank you for participating in this event.

Thank you, Senator Breaux. [Applause.]

[The prepared statement of Dr. Folse follows:]

Greg Folse, D.D.S.

Outreach Dentistry
Special Care Dentistry- Board
Clinical Assistant Professor- LSU
Geriatric Dental Fellowship,1999
LA Oral Health Program Consultant

Thank You Senators Breaux and Craig for graciously hosting this event.

Thank Dr. Carmona for your efforts and your work on the *National Call To Action To Promote Oral Health*

Ageism in Health Care:
Are Our Nations Seniors Receiving Proper Oral Health Care?

NO !!!!

"No less than a ***silent epidemic*** of oral diseases is affecting our most vulnerable citizens—poor children, the elderly, and many members of racial and ethnic minority groups" *Oral Health In America 2000*

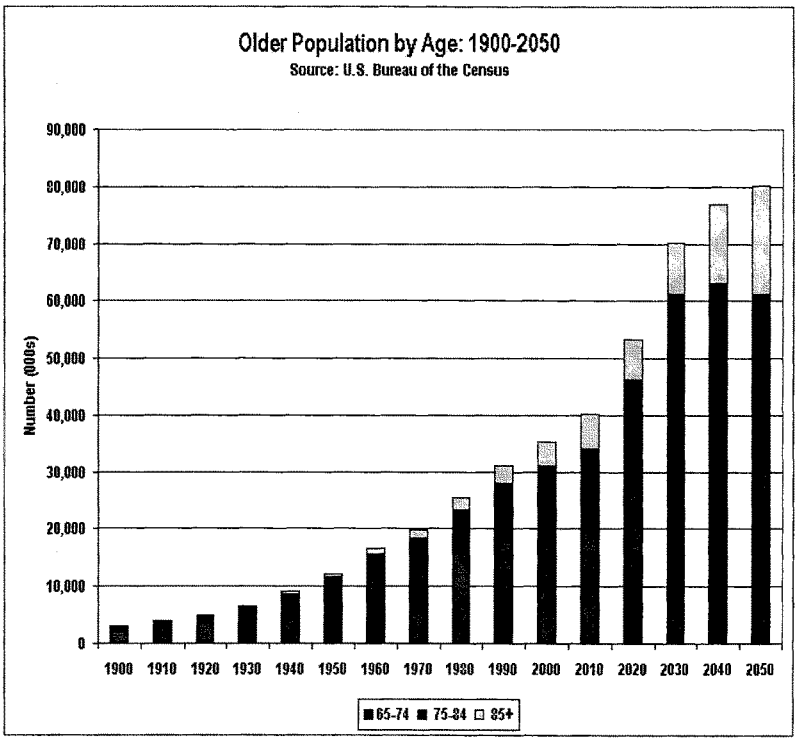
The Issue Before Us:
Many Seniors Needlessly Suffer

Who Are They?

The most critical Population is the
Aged, Blind, and Disabled

How Many?

- US Census Bureau:
  - 35.4 Million Adults Over 65 in 2001
  - 17.8 Million Adults Over 65 in Poverty in 2001
  - 14.0 Million Adults Over 65 Were Disabled in 2000
  - 33.2 Million Adults Over 16 Were Disabled in 2000
  - 1.7 Million Adults In Nursing Facilities
  - And ***Growing***



The Oral Health Of The
Aged, Blind and Disabled
Is Mostly **Neglected**
On A National Level

There are "Profound and Consequential Oral Health Disparities within the US population" especially for the elderly. *Oral Health In America 2000*

- Cavities – Highest %
  - –Elderly
  - –Poor adults
  - –Minorities
- No Teeth
  - –Elderly
  - –Poor adults
  - –Minorities
  - –Less education

Got Money?
Get Care

"***Until***" -You:

- Get Medically or Functionally Disabled
- Get Institutionalized
- Spend All Your Money

Unmet Need

- 66% Of US citizens over 65 have **Untreated Cavities!**
- The **Frail Elderly Suffer!**
- MR/DD adults in communities have **Little to No Access or Coverage!**

For Aged, Blind or Disabled (ABD) Adults Oral Health Services ***ARE*** A Medical Necessity. Many States Deny This - Do You?

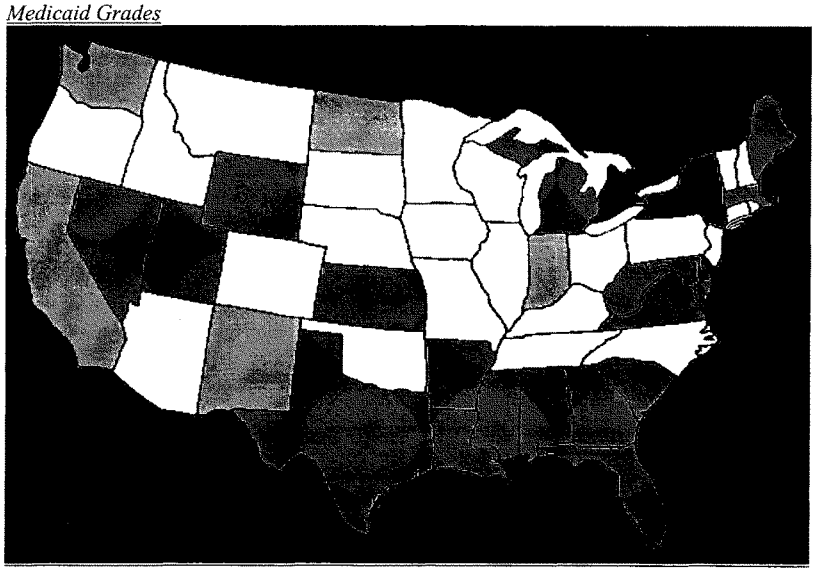
When You Look,
The Silent Epidemic
Screams!

"The frail elderly are just as dependent as children when it comes to health care. Justice compels us to end the willful neglect of our elders. We must assure that everywhere in America they receive the oral health care they need and deserve."
Dr. Micheal Helgeson,
Apple Tree Dental

Aged, Blind, and Disabled Oral Health Benefits: What Is Available?

- Medicare: Virtually None
- Private Insurance: Very Poor – The First to Go At Retirement
- Applied Income Laws (Nursing Facility Residents only): Not enforced, regulated, and are mostly ignored
- Medicaid: ***OPTIONAL*** to Each State

Medicaid Grades



Medicaid Coverage

- Adult services are optional
  45 States D or F
  All States D or F for Service
  Reimbursements (1 C-)

Overall Final Medicaid Grade
D-
Aged, Blind, and Disabled Medicaid Grade
F

Do We Get It Yet??

There Is ***Nothing*** Out There For These Vulnerable Adults

The System Of
Optional Adult Medicaid
Oral Health Benefits
Is ***Not*** Working

- We have, in essence, designated treatment of infection, pain, puss, swelling and functional problems for the aged, mentally retarded, disabled and blind AS OPTIONAL!!!
- The Optional nature of oral health services for Medicaid adults has, at least in part, allowed this epidemic for these poor and vulnerable adults.

Nationally, No Oral Health Infrastructure Exists For Aged, Blind, and Disabled Adults

We Do, However, Have Infrastructure For Children Under EPSDT

National Successes And Opportunities

- CMS
  - Recognition Of MDS Assessment Problems
  - MDS Reform: The work has just begun!
  - Quality Indicators
  - Foundation for PETI Reform
  - Recent MDS data
  - Recent Nursing Facility Deficiency Data
  - Recent CMS policy definitions And Letters
  - APPLIED INCOME LAWS!
- American Medical Directors Association
- Congress
  - Senators Breaux and Craig: Senate Special Committee on Aging
  - Press Releases From Senator Breaux
  - Relationship With Senator Breaux's Office
  - Senator Grassly : Finance Committee
- ADA
  - Working Relationship With SCD and Oral Health America
  - Publications
  - Press Releases – Contacts Generated
- Oral Health America – SCD Geriatric Initiative
- National News Coverage
- LTC Oral Health Coalition
- Promotion Of The Dental Director Model
  - Radar Screen At CMS, ADA, AMDA and Industry

National Solutions:

- We ***NEED*** A Bill
- My Idea:
  Lets Provide ABD Adults Oral Health Services Through Already Existing Medicaid EPSDT Dental Coverage For Children
- "Special Care Dentistry Aged, Blind, and Disabled Oral Health Access Proposal" (Included in My Testimony)
- We Need A Clear Statement That Oral Health Services For ABD Adults Is ***Medically Necessary!!***
- Formation Of A
  National Oral Health Coalition for Special Care Adults
- Formation Of The
  American Dental Director Association

"What are the greatest problems that seniors face where oral health is concerned?"

- There Is No National Mandatory Oral Health Care Requirement
- The Poor Have No $$ For Services
- Optional Nature Of Adult Medicaid Benefits

Is Ageism Involved?

Oral Health Ageism
Exists On Several Fronts:

- Vulnerable Children Have Mandated Medicaid Access – Vulnerable Adults Don't
- Children Specialty Status (Pediatric Dentistry) Vs. None For The Aged
- Specialty Training For Treatment Of Children Is Advanced Vs. Limited For Special Care Adults
- Providers Have Little Incentive –No, Or Poor, Reimbursement Rates, Burdensome Medicaid requirements, Constant Program Threats, etc.
- Get Trained To Take A Pay CUT!
- Provider Persecution - New Mexico
- Many Poorly Funded State Oral Health Programs (Dental Director Positions) Are Funded By MCH Where Elderly Initiatives Are Not Strongly Supported

Is There Lack Of Societal Awareness?

- YES!!!
- The "Forehead-Slap" Syndrome

What Role Does Neglect Play?

- Neglect Starts With Loss Of Income, Insurance, Medical Health, Or Physical Function
- Promoted By:

– Lack Of National Funding and Provider Infrastructure For ABD Oral Health Services
–Lack Of An Oral Focus By Health Professionals

To What Extent Is Oral Health Covered By Insurance Versus Out Of Pocket Expenses For The Elderly?

- 12 Years Of Geriatric Practice:
  Only 4 Patients With Private Dental Insurance!

Aged, Blind, and Disabled Oral Health Access Proposal

Draft May 17, 2003

Rationale

- Vulnerable Medicaid eligible adults with special needs who are aged, blind or disabled have complex physical and medical conditions, more serious dental disease, more missing teeth, and more difficulty obtaining dental care than other segments of the population.
- These vulnerable Medicaid eligible adults with special needs are often dependent on others for oral disease prevention as well as access to oral health services. Neglecting their oral health needs can result in pain, infection, suffering, disfigurement and even death for these vulnerable individuals.
- Nationally, an oral health infrastructure through Medicaid does not exist to provide prevention and oral health service access for this needy population, allowing and promoting oral health neglect and abuse.
- In states where access to adult oral health services is available, the infrastructure is under constant threat of cuts or outright elimination due to the optional nature of adult Medicaid dental care and state budgetary problems.
- Every state already has a federally mandated Early and Periodic Screening, Diagnosis and Treatment (**EPSDT**) service that provides needy Medicaid children with access to critical oral health services.
- Vulnerable aged, blind or disabled adults must be assured access to critical oral health services.

Proposal

- Mandate that in every state adult Medicaid eligible individuals who are "Aged, Blind, and Disabled" (as defined in each state Medicaid Plan) be eligible for the oral health services through each state's EPSDT Medicaid program or through a program with benefits at least equal in scope to the EPSDT oral health benefits.
- Each state must include oral health services relevant to this vulnerable adult population such as adult preventive services, periodontal treatment, adult fluoride application, adult surgical services, replacement of teeth, denture care, house call visits, nursing facility visits, etc.

Eligible Population

- All Medicaid eligible adults at 100% poverty level who are defined by each Medicaid State Plan as "aged, blind, or disabled" would be eligible. Each Plan definition must include at least the same population of Aged, Blind and Disabled as defined by Social Security Law.

Cost

- There are data available in California on the use of Medicaid dental benefits by adult individuals who are designated as "Aged, Blind, or Disabled". These data can be extrapolated to provide a rough national estimate of the cost of the proposed program.
- Details of the calculations are included on the next page.
- Extrapolating the California data yields an estimated cost for this program of $1.28 billion nationally (federal and state combined) to provide dental benefits under state Medicaid programs for adult individuals who are "Aged, Blind, and Disabled."
- Some states, however, are already providing services to this population as part of their optional Medicaid dental programs; hence, the costs of services already provided must be subtracted from the 1.28 billion.
- Medicaid reimbursement rates are higher in California than in many other states, decreasing the relevant costs in those states and thus the national cost estimate.

Pros

- The program would include a guarantee that the most vulnerable of the adult population (i.e. those over 21 who are aged, blind, and disabled) would receive critical oral health services at a predictable cost.
- Additional governmental health care cost savings will likely come from decreased emergency room visits, decreased hospital stays, decreased ambulance and transportation usage, decreased orally induced complications of medical health, less restorative dental procedures needed as preventive services are provided, etc.
- This change would likely also reduce total health care costs by preventing or reducing the number of patients requiring expensive alterations to their diets, diseases caused by poor nutrition, hospitalizations resulting from aspiration pneumonia due to poor oral health, bacterial endocarditis, oral cancer, diabetic complications.
- A modest investment in effective prevention, early diagnosis, and early treatment will improve quality of life for America's most vulnerable adults.
- This change would add little to no additional costs in of states that already provide the level of coverage required.

Cons

- This change would add costs for dental programs in states that currently do not provide critical adult oral health services to vulnerable adults.
- Given the current efforts at cost curtailment in many states existing optional Medicaid adult dental programs could be cut. It should be noted, however, that over recent years many states have already cut or eliminated adult dental services without providing any safety net for the critical oral health needs of their most vulnerable adults.
- Although the need for this federal legislation is obvious, a state mandate will not be popular for some.

- **Estimated Cost of National Dental Coverage for Medicaid Recipients who are Aged, Blind, Disabled: Cost Calculations**

Population Estimates

California Population, July 2002 = 35,116,033
Reference: http://eire.census.gov/popest/data/counties/tables/CO-EST2002/CO-EST2002-01-06.php

National US Resident Population, July 2002 = 288,369,000
Reference: http://eire.census.gov/popest/data/national/tables/NA-EST2002-06.php

Therefore California Population = 12.18% of US population

Assume California has average rates of Medicaid eligible people and people who are aged, blind, and disabled. Note that California has a full service Medicaid program for adults.

California Medicaid utilization by "Aged Blind and Disabled" Medicaid recipients

From DHS Report MR-0-645 - Total for All Counties, Denti-Cal Users and Expenses 01/01/02 to 12/24/02
(Data compiled and analyzed by Paul Glassman DDS, MA, MBA, May 2003)

Adults (>18)	#	%	$	%
% of total users and payments >18 (estimate)		51.23		61.77
Disabled	235,672	8.97	$101,085,071	13.10
Blind and Disabled	241,651	9.20	$103,488,095	13.41
Aged, Blind Disabled	368,749	14.04	$156,286,488	20.25
Cost per individual - Aged, Blind, and Disabled			$423.83	

Estimate of National Cost based on California data

If California population = 12.18% of US population, then national cost (federal and state) would be $156,286,488/12.18%

Therefore the estimated cost of national dental coverage for adult Medicaid recipients who are "Aged, Blind, Disabled" based on California data is: **$1,283,140,291.56 ****

This projected cost is the upper limit – See the **Cost section on the pervious page.

Senator BREAUX. Thank you very much, Greg.

I met with Greg previous, and I had seen his presentation back in Louisiana, and it was what really got me interested in trying to figure out where we are as a Nation with regard to oral health care for seniors.

Let me just start—and I want you all to enter into discussion, not me—I would rather just sit and listen—but Greg, you made a statement that Louisiana has a good program.

Dr. FOLSE. For denture care only.

Senator BREAUX. Oh, for denture care. Explain the difference between oral health care and just denture care that we have in Louisiana.

Dr. FOLSE. Oral health care would include extractions, would include all the preventive services, exams, x-rays, getting teeth cleaned, gum disease treatment, fillings. That is an oral health care program.

What we do is only the prosthetic side, which is a piece and an important piece of oral health, but we make dentures. We do not take out bad teeth to give you dentures, but we do provide dentures for patients whose teeth are already gone.

Senator BREAUX. That is really interesting; we are after the fact.

Dr. FOLSE. The program was started years ago when most of our elders—in our State, probably 65, 70 percent of our elders had no teeth. Now I am seeing only about 40 percent; so I am seeing 60 percent with teeth now. So back then when they started that program, a majority of the population was affected by it in a positive way. So it made sense back then.

Senator BREAUX. So the State Medicaid program covers the dentures?

Dr. FOLSE. Yes, sir, they do.

Senator BREAUX. You are really pointing out something. Older citizens, like my grandparents' generation, were just expected to lose their teeth and never to have all of their teeth.

Dr. FOLSE. Exactly, yes, sir.

Senator BREAUX. OK. The information is obviously very graphic. I think we have a problem, and the question is how extensive is the problem. Can anybody talk about that a little bit? I have seen Lafayette, and I have seen Louisiana, but what about the study that we did with oral health?

Robert, do you want to comment on that? How did you all do the survey?

Dr. KLAUS. We surveyed Medicaid dental contacts across the United States. I would suggest that the study results that we see here today are really the tip of the iceberg, that the problem is probably far more serious than even we would come out and say.

Senator BREAUX. What kinds of programs do we have for oral health care among the States? I guess the States' obligation would be under the Medicaid program for the low-income.

Dr. KLAUS. Medicaid—but under the Medicaid program, the first thing to be cut when times get tough in State legislatures as they are now, with States facing huge deficits, is the dental benefits of Medicaid. Recently, Michigan cut all Medicaid benefits except for those that relate to emergencies.

We think that this pattern is going to continue. I just heard this morning from people in Georgia that next year, they think they are going to cut back on their dental benefits for Medicaid.

Senator BREAUX. Is the best that any State has under Medicaid an optional program that covers dental?

Dr. KLAUS. Yes. They are all optional.

Senator BREAUX. They are all optional, and many of them do not even have them as an option.

Dr. KLAUS. No, many of they do not have them as an option.

Senator BREAUX. Greg.

Dr. FOLSE. Correct. The children's program is not optional, but all programs for adults are. You get a range of different types of programs. Minnesota right now is doing very well with their program. There are little problems within individual programs, and as a whole, you have Medicaid issues nationally. But it is optional versus non-optional.

So from Minnesota, which is doing well, treating a lot of nursing home patients and a lot of elderly across the State, it goes down to States with absolutely nothing, not even a denture program; so you have us all in the range.

The effectiveness of those programs, though, comes in when you really grade it, and that is what the report card did. We cut out five different procedures and looked at the reimbursement rates and said what dentist is going to do this for these types of fees, and that is where we got all the D's and F's. It was just way below what is out there.

Senator BREAUX. We sent all of you some questions, and I want to try to keep it focused to a certain extent. The first question is: What is the greatest problem that seniors face where oral health is concerned?

If you are poor, the greatest problem is you do not have it. Anybody can start to comment on this. My father fortunately has access to his employer's retirement health program that covers dental care. He probably also has enough money that if he did not have that insurance, he could afford to go to a dentist and pay the bill.

But that is probably not the situation for most Americans. Let us talk about that.

Paula.

Dr. FRIEDMAN. Senator, thank you for this opportunity to comment. I think that this is a tremendously important issue, and I would suggest that we consider, in additional to the financial means to access care, the dearth of qualified providers. One of the reasons that there is a problem certainly is financial, but another level of problem is that there are so very few qualified people trained in geriatric dentistry. A few of them happen to be seated around this table. But I would ask you to think about how many dentists are trained annually to provide the special training to provide care to senior citizens. I am not going to put you on the spot, but I am sure you would not imagine. Under HRSA—and we are grateful for the support that HRSA provides toward training geriatric physicians and dentists—less than 10 dentists a year for the entire country are trained in providing special services to this frail elderly population with medically compromised, complex medical conditions.

So I certainly recognize the financial aspect, no question about that, but I am sure that my friend and colleague Dr. Folse would agree with me that access is also a function of having qualified providers.

Dr. FOLSE. Without a doubt. It is kind of what comes first, the chicken or the egg, because I have had 3 years of extra training so that I could take literally a 50 percent pay cut over my colleagues. So what is going to come first? I do not think we could get the—you almost have to have the financial infrastructure at the same time. I do not care which one gets there faster. We have got to do both of them, and you are exactly right.

Dr. FRIEDMAN. You certainly have to address both. I happen to be one of the dental directors of one of the HRSA-funded geriatric dentistry and medicine training programs, so I can tell you that there are only five to seven dentists per year in the entire country.

Senator BREAUX. Well, we only have five medical schools, and we just recently picked up two more, but out of all the medical schools in the country, 113 or so, there are only five that offer graduate programs in geriatrics. It is the fastest growing segment of our population in America, and yet only five medical schools offer advanced degrees in geriatric specialties. So when you break it down to subspecialties of dentistry, you can understand why we only have 10 graduates a year.

Yes, Mr. Harrell.

Dr. HARRELL. I am a consultant to a nursing home, which I do mostly on a free basis—I take a 100 percent cut—and we have a Medicaid program that covers adults, although the reimbursement rates are extremely low, sometimes as low as 14 to 16 percent of cost.

Senator BREAUX. Who has the program?

Dr. HARRELL. North Carolina.

Senator BREAUX. Oh, the State does—under the Medicaid program?

Dr. HARRELL. Although we fear we are going to lose it. I think the only reason we came out so well this year was the one-time Medicaid reimbursement to the States which saved us from probably a lot of lobbying and a lot of heartache. But this is going to come back again next year. But it is a financial issue. As a family dentist, I see geriatric patients in my office on a daily basis. A lot of them have insurance or can afford it otherwise, or they would have Medicaid. But going into a nursing home facility—I serve three—there are no facilities, no equipment. The nurses and staff know very little about oral health, and most of the time you are doing extraction in the middle of the night with a weak flashlight battery, and they always feed them right before you get there. I do not understand that. So I know we need geriatric dentists—I am not underplaying that—but we need to stimulate family dentists.

Senator BREAUX. I would think—and I am obviously not a medical doctor—but it would seem to me that the fact that we do not have a lot of geriatric dental specialists, it seems to me that any doctor of general dentistry can look at these seniors and the problems they have are no different than those of a young child who has not been to a dentist in 15 years of his life. I mean, a practicing dentist would be able to look at an elderly person just like

he does a person who has never seen a dentist who is 20 years old as the same types of problems develop. There are a lot of other problems, particularly mental illness and others, that seem to be a lot different among the elderly and more difficult to recognize that it is a problem of aging.

Dr. HARRELL. There are special needs patients that you cannot treat without some type of facilities, and in a lot of places, we do not have those.

Senator BREAUX. I would bet you there is not a nursing home anywhere in the country that has a resident dentist.

Dr. FOLSE. I am actually a dental director in 14 nursing homes now, and I am there usually a time or two a week, and we do all of our services. I do do some extractions and cleanings and those kinds of things at the facility——

Senator BREAUX. But how many other dentists do that?

Dr. FOLSE. Not many. To build the infrastructure that we are going to need to get people doing those kinds of services, one of the things is to take away the yearly budgetary threat that we get from Medicaid on a State-by-State basis. That has a significant impact when you have a system built to treat vulnerable adults, but it is always on target. I have trouble getting other dentists to do that when the States pull the rug out from under us every year.

Senator BREAUX. But what kind of compensation does a dentist who does what you do get? Is he reimbursed anywhere?

Dr. FOLSE. I am reimbursed for the denture care, and a lot of the other stuff is donated.

Senator BREAUX. We know these other problems are not denture problems; they are just gum disease problems. You are not going to be reimbursed zip for that.

Dr. FOLSE. But I am not treating it, either. It is sad. I have 2,500 patients, and 1,600 patients have cavities and gum disease under my watch, and they do not get treated. I put the fires out as much as I can. I treat the ones that the families will let me treat. But as a whole, having an infrastructure where guys in an office could get paid to see these patients and I could refer them to you would be great.

Senator BREAUX. Are there any other comments from anybody?

Dr. Barsley.

Dr. BARSLEY. Senator Breaux, I appreciate the opportunity to be here today.

I have worked with Dr. Folse over the years in Louisiana, and one of our problems has been I have pulled the rug out from under Greg more than once when our State ran out of funds; I have reduced the amount of money that we can pay to him. Fortunately this year, we were able to increase that amount of money, and one thing we thought about doing was increasing the services that were offered. Our problem was that the pent-up demand is so vast that once we increase the range of services we can offer, we have no way to judge how much pent-up demand there would be; if we had to extract just one tooth in every person in Louisiana who is Medicaid-eligible, that is one million teeth.

Senator BREAUX. How much do we pay for dentures?

Dr. BARSLEY. We pay roughly $1,000 in Louisiana.

Senator BREAUX. I mean what is the total cost.

Dr. BARSLEY. In Louisiana, our budget for adult services is about $4 million.

Senator BREAUX. Four million dollars for dentures.

Dr. BARSLEY. For dentures only and the exams that go with them, yes, Senator.

Senator BREAUX. Suppose we just did not do dentures, and we used the $4 million for oral health?

Dr. BARSLEY. That is what I am looking at.

Dr. FOLSE. Yes.

Senator BREAUX. Is there any prohibition—I mean, could a State do that if it wanted to?

Dr. BARSLEY. Senator, we could, but I am very much afraid—in fact, we are discussing this very weekend adding dental care for adult pregnant women to help decrease low birth-weight children. We are estimating that adding extractions and cleaning their teeth will probably cost about $3 to $4 million for the 30,000 women who would be covered in the next year. So if we were to cover all the Medicaid-eligible people in Louisiana and cover a range of services limited just to that——

Senator BREAUX. Does anybody know if any other States just cover dentures?

Dr. FOLSE. That is optional. I mean, you can cover whatever set of benefits you want.

Senator BREAUX. Yes, I know, but I think it is unusual that we cover dentures but not oral health.

Dr. FOLSE. Yes.

Dr. DOLAN. Senator, the State of Florida had an adult denture program until about 2 years ago, and when they had Medicaid cuts, they eliminated that program. That is why my State is a "red" State on Dr. Folse's chart, because actually, we have one of the highest proportions of older adults in the United States, and yet we do not have the ability to serve the needs of those individuals.

Senator BREAUX. So Florida is not able to do dentures or anything else in oral health?

Dr. DOLAN. No. In fact, I was the dental director for four nursing facilities in Florida as part of my teaching responsibilities at the University of Florida and was faced with the same frustrations that you face every day in that you try to do the right thing for these individuals, and yet there was not the public or private financing to meet the needs of the residents of these facilities.

Dr. FOLSE. Senator, I beg your forgiveness for the interruption. You are talking about cost. In special care dentistry, we looked at the problem of including oral health for adults in Medicaid, and when you cover the whole population, it costs a lot of money. You are really in a jam. You are not able under Medicaid to carve out like "aged, blind, and disabled."

If we could carve out "aged, blind, and disabled," which is the most vulnerable population, and cover them under Medicaid, that is a doable thing. We put together as part of my written testimony the proposal—we looked at what California spent on "aged, blind, and disabled"—and they have full dental benefits there—and we extrapolated that out to the country, and it looked like about $1.2 billion a year if you put those patients under the dental programs that are currently there. That is pretty much a max, because some

of those patients are already being treated, so the ones like California would be included in that $1.2 billion, so we are already spending that. It would probably add from our estimation about $700 million a year to the country to treat "aged, blind, and disabled" under Medicaid. It just makes sense.

Senator BREAUX. Would you have to drop others—aren't children included?

Dr. FOLSE. Children are covered now under Medicaid; correct.

Senator BREAUX. You are not talking about dropping them.

Dr. FOLSE. No. I am talking about just adding ABD adults into the EPSDT program that is already existing in all the States.

Senator BREAUX. Does anybody have any thoughts about that?

Yes, Paul?

Dr. GLASSMAN. Paul Glassman, from Special Care Dentistry. Thank you for the opportunity to be here.

Greg is referring to some data that we did collect in California, where the people who were in that category, adults who are "aged, blind, and disabled," account for 33 percent of the Medicaid population in California and currently use about 20 percent of the Medicaid dollars. So that is where the numbers came from to extrapolate what it would cost nationally. California actually received a C-plus on the chart, which was one of the three highest States because of that program—although that program has been threatened and almost went away this year. Again, the one-time block grants to the States saved it from being removed this year.

I also wanted to comment that—you asked earlier about data—in the recent Surgeon General's Report on Oral Health in America, it actually says in the report that one of the problems when you are talking about special populations is that there really is not any good data, and it actually talks about that in the report.

I am president this year of Special Care Dentistry, and we have 1,000 members, which is a small group of very dedicated people who spend their lives treating people who are aged, blind, and disabled, and each one of those people has a thousand stories. So there is no question in our minds that this is a huge problem. The numbers are staggering, but as Greg says, it tends to be a silent epidemic because the people who are suffering really do not have a voice to let their suffering be known.

Senator BREAUX. Tell me again what is your situation in California. The aged, blind, and disabled constitute about 33 percent?

Dr. GLASSMAN. We have an adult Medicaid program for dentistry, so adult Medicaid recipients are covered by dental benefits. Of those who are covered, about 25 percent fall into the category of "aged, blind, and disabled," and they use about 20 percent of the Medicaid expenditures.

Senator BREAUX. What does the program in California cover?

Dr. GLASSMAN. I cover all the kinds of things that Dr. Folse was talking about—basic examinations, cleanings, fillings, extractions, treatment of infections, screening for oral cancer. It does cover dentures. Some people say that it does not cover enough, but I actually think it is a very good program for basic services.

Senator BREAUX. But how did they only get a C if they cover all that?

Dr. KLAUS. Because they missed in other major—I do not have the report right in front of me, Senator—but they missed in other major categories. Paul, you probably know those better than I do.

Dr. GLASSMAN. I think it is actually a good program compared to many States in the country. It certainly has its problems, and I think that is where the C came from.

Senator BREAUX. So you miss seniors who are not aged or disabled or blind; they are not covered?

Dr. GLASSMAN. Yes, that is right. Low-income seniors are covered.

Senator BREAUX. All low-income seniors eligible for Medicaid have dentistry as an option.

Dr. GLASSMAN. Right, yes. Most people who are eligible for Medicaid gets dental benefits, right.

Dr. FOLSE. Their low grade came from real low reimbursement rates.

Senator BREAUX. Other than that, they have a good program. It is just a question of the reimbursement rates—because the services are provided.

Dr. FOLSE. Yes. A lot of the States have full coverage is what they say, but when you look at the effectiveness of that coverage, because it is below the tenth percentile of what dentists charge, it is real hard to get the infrastructure.

Senator BREAUX. That is true of everything—in the CHIP program in my State of Louisiana, we have insurance for children under the Medicaid program, but the reimbursement rate is so low that many doctors refuse to take children as patients because of the reimbursement rate. It is all a question of money, isn't it?

Dr. FOLSE. Yes.

Senator BREAUX. Is there other discussion on this?

Yes?

Dr. HARRELL. I wanted to bring up the reimbursement to make sure you are clear. States have programs; it does not necessarily mean they fund those at a reimbursement level adequate enough for people to have access. In North Carolina, by a funny twist, the State was just successfully sued by a children's advocacy group because they did not raise the fees, the reimbursement, enough to allow the required access. The funny thing is—not funny—but the nice irony is that they did it by codes, and a lot of those codes are also adult codes. So that is going to help our geriatric Medicaid population also. But just because you have children's Medicaid or a Medicaid program does not necessarily mean you are providing access.

Senator BREAUX. Let me understand. How many States have dentistry covered under the Medicaid program, regardless of the reimbursement rates?

Dr. FOLSE. Virtually all of them.

Senator BREAUX. So all of them do—Louisiana, too? I thought we just covered dentures.

Dr. FOLSE. There are I believe eight States with no services at all, and this is from some data that I had about a year ago, so I am doing it by memory. I think we had eight with none and 22 with either limited or emergency only, and the rest of the States

had what they considered full coverage for adults. For children, everyone is required to have full coverage.

So the heart of this would be taking "aged, blind, and disabled" and saying you must cover them also, and that is where ageism comes in to me. We have a vulnerable child population, and we have the same issues on a vulnerable adult population, but we do not have the same requirements. I would love to see that as a requirement.

We could increase the FMAP for the States, too, the Federal matching dollars. If we increased that for that program, it would be a really nice thing that would fly politically—with a big question mark.

Senator BREAUX. I'm not sure what flies politically today.

Dr. Davis, what about CMMS? Can you comment on what we have been listening to here?

Mr. Davis. The latest number that I have on the number of States that do provide adult dental care is 8 for full benefits, 16 for limited benefits, 18 for emergency-only benefits, and 9 that have no coverage at all. Those are the current numbers right now on the Medicaid side.

Senator BREAUX. Karen.

Ms. SEALANDER. Karen Sealander with the American Dental Hygienists Association.

While there are many inevitable declines in seniors' health, a decline in oral health is preventable, and that is why it is such a tragedy to see Dr. Folse's slides; because if seniors receive regular preventive services, we could prevent all of these horrible oral health tragedies.

While the profession of dental hygiene was founded back in 1923 as a school-based profession, over the years, hygienists have lost many outreach opportunities. One solution to the oral health care crisis that ADHA would like to see is increased entry points into the oral health care delivery system. Even seniors who have insurance, whether it is Medicaid or private insurance, often cannot get access to care because they cannot travel to a dental office. So we need to go out and reach these seniors where they are, and ADHA would like to see dental hygienists play an increasingly important role in delivering care to people where they are, whether that be in a nursing home or an assisted living facility.

In many States, there are restrictive supervision requirements, but there are some States pioneering less restrictive requirements, and ADHA would like to see that encouraged.

Presently 25 States allow hygienists to provide services in nursing homes; 12 States recognize hygienists' ability to provide services to homebound patients; and 10 States recognize hygienists as Medicaid providers. ADHA would like to be part of this solution in a collaborative way. Dental hygienists cannot provide all oral health services—we need to work in conjunction with dentists—but hygienists would like to be able to reach more seniors with our services.

Senator BREAUX. Let us talk a little bit about that. I do not want to get into a battle between dentists and hygienists, like we have done over the years with psychiatrists and psychologists and chiropractors and medical doctors, et cetera, et cetera. But there are two

questions. No. 1, how much help can dental hygienists provide if they were involved in treatment of our elderly citizens, and No. 2, if they can be of help, how many of them would be available considering the shortage of dentists that we have?

Can anybody talk to me about how much help they could be?

Ms. SEALANDER. Senator Breaux, with respect to the historic turf battle, there is more than enough unmet need for all of us to play a significant role, so there is really no need to squabble over turf.

With respect to the workforce issue, the number of dental hygienists in the workforce has grown steadily and is expected to increase by 37 percent between 2000 and 2010. Dentists, on the other hand, are among the five health professionals with the slowest rate of job growth, a 5.7 percent increase projected between 2000 and 2010.

Right now, approximately 5,500 dental hygienists graduate each year and about 4,300 dentists graduate each year. Morever, dental hygienists are educated to care for geriatric patients; geriatric care is a required part of the dental hygiene accreditation standard.

Because dental hygienists provide preventive oral health services; and do not provide restorative services, hygienists to work in connection with dentists, and hygienists can serve as a pipeline to dentists. One hygienist in Portland, OR provides services in a nursing home in an onsite dental clinic that was built with donated equipment. She works there one day a week, and then, one day a month, a dentist comes in and provides the needed restorative care.

Dr. FOLSE. They would be an integral part of the team, and I think hygienists are going to be integral in the final solution of this; they are going to be a big part of it.

Senator BREAUX. Anybody else?

Paul, and then Jim.

Dr. GLASSMAN. You are touching now on workforce issues, which I think are going to become a major problem. This problem that we are talking about now with elderly and disabled people having difficulty getting access to care is going to get worse because of workforce problems.

It certainly is true that the number of hygienists is growing faster than the number of dentists. Dentists who are retiring now went to school at a time when there were 6,000 dentists a year being produced, and they are being replaced by today's 4,000 graduates.

The thing I want to point out, though, is in all of the estimates about how critical this workforce shortage is going to be, all those estimates if you look at them carefully are based on an underlying assumption, and that assumption is that those people who are currently left out of the oral health system who do not have access to oral health are going to continue not to have access to oral health. All the analyses on workforce are based on that assumption

Senator BREAUX. DR. HARRELL.

Dr. HARRELL. The American Dental Association has consistently studied the workforce issue, and there are some problems with some of the data, and it is hard to project the needs in the future. We recognize the value of hygienists, particularly as Greg said in a team concept, where the dentist does the diagnosis but the hygienists particularly are extremely valuable, I think, on the education end of this thing.

I looked the other day, and there are 44 States—our policy in the American Dental Association is that it is sort of a States' issue, but 44 States have chosen to give some laxity of supervision to hygienists in nursing homes. Whether that has increased the care, I do not know. The only concern is that the diagnosis is done so that we do not just polish decay but that we really give treatment.

Senator BREAUX. Yes. It seems to me that some of these people who are institutionalized, not to mention those who are not in institutions, but all those who are in assisted living facilities or nursing homes, never really have anyone look into their mouths to see what kind of oral health they have. A dental hygienist could certainly help identify serious problems that necessitate a dentist to do the extra work that may be required, but there is an awful lot that could be done just to help identify the problem and help with at least a partial solution to the problem.

Dr. Collins.

Dr. COLLINS. Thanks, Senator.

Like others, I appreciate the opportunity to be here. For the moment, I would like to make three points.

One is about the reimbursement issue, which is obviously a complex one, and you have heard a lot of different statistics about what is covered and what is not covered. The key issue to me is that the service is an optional one regardless of where you are in the United States, so that when times get tough, things that are optional tend to disappear. This is the solution that Greg is offering as an attempt to address that.

The second point I want to make is about education and training, looking at alternate solutions—not necessarily training an entire workforce of geriatric specialists—that is probably very impractical, although I would certainly encourage us to have a core of them; certainly we need them as faculty to teach, we need them in programs where they can take referrals for the more difficult, and we need them to educate of general dentists in order to get treatment to these older patients, who yes, may have the same kind of disease, as younger patients but they also have many co-morbid conditions that make it difficult to treat them and that add special conditions that require consideration.

In some of the material that was provided in advance of the hearing, it has been reported the dental schools, that have made considerable progress in offering didactic material—in geriatrics nearly all of them do now—but clinical training has lagged behind.

I graduated from dental school in Philadelphia in 1971, and there was no geriatrics in my course of study; there was very little public health. Downstairs in a little, obscur room, there was something called a special patients' clinic, and I had an instructor who by chance got me involved in that clinic, and I think it made a big difference in my interest in this area and in public health in general, because you got an opportunity to understand that these people had needs like everybody else, and they were eminently treatable if you had the right skills and you understood that.

So that is definitely one of the three legs of the stool. You have to have practitioners who understand that whether they are dentists, whether they are auxiliaries, whether they are hygienists.

The third point I want to make is in the area of research. In the Surgeon General's Report, he talks about science being the lead and the connection for us to make progress in this area and many other areas in oral health. I definitely think there are many opportunities, some of them linking the reimbursement and workforce issues, maybe done through the universities, looking at different distributions of personnel and how well they can address problems, whether the elderly patients are in the community or they are in the institutional setting, because in either situation, it is not a matter of one size fits all. We used to make assumptions—and I think that is why there are so many denture programs or priority on dentures—that people were going to lose their teeth, and if they lost all of their teeth, then they were going to need dentures. Our other priority was kids. So we had denture programs, and we had basic programs for kids.

Times have changed rapidly as dental insurance has grown. We have people with complex medical problems, but they also have complex dental problems; they are moving into old age, and suddenly, they do not have reimbursement for this care, and as they develop other kinds of co-morbid conditions, they have problems.

There is a vast opportunity for us, I think, in the research arena, delivering care in many cases at the same time, to find solutions that use resources wisely—give patients what they need; do not give them more than what they need.

Senator BREAUX. A good point.

Paula.

Dr. FRIEDMAN. Thank you, Senator.

I wanted to point out a workforce issue agenda that is actually interdisciplinary, and it speaks to the need for increased education in oral health across all health care disciplines, and the invisibility, if you will, of oral health care among other health care providers.

I brought with me for the purposes of this hearing two publications that just came out. One is a Public Policy and Aging Report produced and published by the Gerontological Society of America called "Emerging Crisis: The Geriatric Care Workforce," which speaks about the dearth of health care providers across all health care professions, except that oral health is not even mentioned here. There is no mention of oral health in this well-respected association's publication on the workforce crisis.

The second one is a joint publication by the Merck Institute of Aging and Health, and again, the Gerontological Society of America, called "The State of Aging and Health in America," which again does not mention oral health at all.

So I think that when we talk about workforce issues and about increasing awareness of oral health as an important and critical component of overall health, which was mentioned by Surgeon Everett Koop many years ago, it is very important to not only consider the oral health professions but interdisciplinary professions as well.

Senator BREAUX. That raises a question, Greg, with your slides, and I am sure that any State you go to, you could go to a senior facility and see the same problem, maybe some even worse certainly, maybe some not as bad. But why doesn't a regular medical doctor when doing a normal check on an elderly American—any-

body can look into someone's mouth and say look, they have a dental problem. I mean, I could look in there and say this is a dental problem before it got to the point where it got there. You did not need a dentist to tell those folks in your slides that they had a problem long before it got to that point.

Do doctors not notice this, or ignore it, or just do not look?

Dr. FOLSE. I have had a lot of interaction with the American Medical Directors' Association. They are the doctors who go into the nursing homes. I teach them about this, and I called it "the forehead slap"—when you talk about it and they go, "Oh, my God—I am not even looking." I see that time and time again. I call it "the forehead slap factor," and I have it on an additional slide.

We have a long way to go in that regard. I think, though, that as we gear up as I have in my area and as other dentists have around the country, when you gear up an oral health program, they start thinking about it. Then, when you have a few patients who have complex problems and you point it out to them, they start looking. But it needs to be part of the normal routine, and it is not right now.

Senator BREAUX. Teresa.

Dr. DOLAN. Senator, I had the good fortune as a recent dental graduate to participate in a VA fellowship training program which was multidisciplinary, where I worked with the nurses and physicians and physical and occupational therapists, and we learned from each other. That was one way of sensitizing them to oral health issues that they were probably never exposed to during their usual curricula.

Also in the VA, they had dental operatorie in the nursing facility, and we provided preventive and restorative care with dental hygienists, and it was a wonderful model.

Over time, those programs disappeared, so we had probably fewer than 30 trained geriatric dentists who had that experience.

Senator BREAUX. In VA facilities?

Dr. DOLAN. In VA facilities. Many of those VA trainees are in this room and have become the academic leaders in geriatric dentistry.

When I joined the University of Florida, we had a 6-year HRSA training program, also multidisciplinary, with physicians, dentists, and other health care providers, where we learned from each other. Physicians learned about oral health. We learned from physicians about medical complications that were important in dental therapy. Again, those programs were severely cut in Federal budget cuts. I believe that now there are fewer than 10 individuals being trained in those programs. We no longer have a program in the State of Florida.

I think models have been tried and have been successful, but they require commitment and resources. I think we do have a lot to learn from each other. If you look at the medical education curriculum right now, there are probably less than 10 total hours of instruction, in a good school, about oral health issues.

So I think there are many, many areas that need to be addressed. We have had models in the past that have worked and for one reason or another are no longer funded and supported.

Senator BREAUX. Yes, Dr. Musher.

Dr. Musher. Senator, I am a physician. I am board-certified in family practice, and I am a fellowship-trained geriatrician. I am also a past president of the American Medical Directors' Association, so I was happy to hear comment about that.

One of the things that that organization has been trying to do is help educate our medical directors who by law have to be in nursing homes related to the different issues that are important in nursing homes, and one of them is oral care.

But I do want to mention in my training as a fellow that I was trained in oral care. I reach a point, just as anyone else, where I would find a problem in oral care and I would need to find a dentist or an oral surgeon to help care for that problem.

But I think we are saying two important things here. One is the team approach, and the second part is education. In the nursing homes, we have what is called the minimum dataset, and in part of that, we are supposed to be assessing for oral care and looking in our residents' mouths, our patients' mouths, and assessing for certain problems.

I have heard a lot of people have advocate for education, and I think that is critical. I think we have to better educate the staff in the nursing homes all the way down to the CNA level what to look for and then how to plug that patient into the system, and I think they can be educated. They are with the patients every day. They are helping brush their teeth, taking care of their dentures, et cetera, et cetera, so I think that would be important.

I think educating physicians to work with dentists and other health professionals is part of that. I think there are a lot of physicians who are still in nursing homes that are not as well-trained or feel as comfortable, if you will, looking in patients mouths.

I also wanted to comment that, for example, a lot of the patients we are seeing now in the nursing homes are frail, they are demented, they are a little harder to care for in some of these ways, but there are some simple things besides what we have heard today that I struggle with every day such as xerostomia, which is just a dry mouth, either from medicines or just from the aging process, which has huge repercussions. I have had patients who were going to get gastric feeding tubes because they stopped eating because you need saliva to taste the food. My patients were not tasting the food, and they stopped eating. As soon as that was brought to my attention, I realized it was a dry mouth.

That is something simple that anybody could hopefully recognize and correct. So I think it underlines again that more education is critical.

I guess one side comment because I also have a private practice, and one of the things that has frustrated me—and maybe it gets to the financial issue a little bit—is that I think if there were less paperwork related to billing issues, maybe the health care system would not be as costly.

Senator BREAUX. Thanks, Jonathan.

Robert.

Dr. KLAUS. It seems to me and to Oral Health America that there are two chapters in health history in the United States. One is overall health, and then there is oral health. This has contributed to the problems of oral health being perceived in almost abject

isolation and what we call almost a militant indifference—and it is not just us. Listen to how the Frameworks Institute, a think tank in Washington, DC., describes the problem.

"You cannot solve a problem that is not perceived to exist by the public. To say that this issue has not emerged in public discourse is to greatly understate the issue. It is invisible." I would suggest just looking around the room—and I do not know everybody here—but we are all part of the oral health family, and the solutions to this problem will not be advanced, Senator, until we begin to get outside and get coalitions that speak to this issue as passionately as we do.

Senator BREAUX. That is a good point. I have always said that in solving problems, first, people have to understand that there is a problem, and after you realize there is a problem, you can talk about possible solutions to the problem. The third part of any program is to convince people that these solutions are worth pursuing and worth investing a financial commitment to help pay for what you think is the right solution.

So first, you have got to recognize that there is a problem, and that is what we are trying to do and to try to let more people know that the oral health of our Nation's seniors is a severe problem and is one that can be corrected.

Then, we have got to come up with some ideas of what should we be doing. Greg suggested trying to make sure we at least cover aged, blind, and disabled seniors. We could start in that area.

Then, you have got to have the political wherewithal to go out and sell that proposal.

So it is a three-step process. It is not rocket science, but it takes some commitment on the part of people.

Somebody else had a point. Paul, first.

Dr. GLASSMAN. Just to extend this discussion about awareness and are people seeing things or not seeing them or ignoring them, I think it is a combination of both. It certainly is a gigantic awareness problem where people look right past the mouth and sometimes do extensive medical tests, workups running to thousands of dollars for somebody and it turns out to be a dental problem.

I spent 20 years working in a hospital dental clinic where that would happen time and time again. You would have someone who was in the ICU and had been there for a week and had had all kinds of expensive tests and then finally, in frustration, giving up and saying, "Let us call a dentist in," and you would look, and sure enough, there would be a dental infection, and that was what was causing the problem.

I supplied a videotape to your staff of an adult lady who was not verbal and mentally retarded who was admitted to a locked psychiatric facility in California at a cost of $150,000 a year to the State of California because she was exhibit bizarre behaviors and lashing out at people around here. Luckily, there was a dental hygienist in our State who was connected through a program we have who came in and saw her and thought maybe this was a dental problem. Because we have adult benefits in California for this group, they were able to see her, and within 24 hours after dental treatment, she was back to her normal behavior and back living in the community again.

That was a pretty dramatic story. So I think we have a giant awareness problem, but I think we also have a giant frustration problem, which is imagine that you are a physician or a social worker or a nurse and you are in a nursing home or working with a group of disabled people, and you look in the mouth and you recognize there is something wrong, and you try to get someone to come in and see that person. How many times are you going to try? You dial the phone, and you call 20 dentists, and after a while, you give up, and you stop looking, and you stop trying to even bother because you know you are not going to get anyone to come in and see them.

So we need awareness, and when someone does become aware, we need to have something that they can do that is going to work.

Senator BREAUX. That is a very dramatic story from a cost standpoint.

Dr. HARRELL. Senator, we appreciate you taking your time this afternoon, by the way.

I want to make two points. I just participated in an Interfaces Conference which dealt with children's dentistry, sponsored by the American Association of Pediatric Dentistry, and they had a group similar to this. The physicians in the group did state pretty overwhelmingly that—I think they would have caught some of the slides that Greg had—but especially a lot of the subtleties of oral health, they were not trained in. In fact, none of the doctors present were. I thought that was interesting.

Second, with Dr. Folse and some of the people who are sitting here, we are developing an oral health assessment and survey process for nursing homes, and CMS is reviewing that right now. Basically, we would like to at least have the right questions asked, hoping to raise awareness on oral health needs.

Senator BREAUX. Tell me about what. What are you all submitting?

Dr. HARRELL. It is called an oral health assessment and survey. It is for nursing home patients, and the nursing home fills it out. That is being produced right now; CMS I think is reviewing it.

Senator BREAUX. Do they do that now, or not? Is it a requirement to do that now when a patient enters into a nursing home?

Dr. FOLSE. Yes, yes. In every nursing home chart, there is a health questionnaire called the MDS, and on the MDS are seven different oral health questions, and those questions have a lot of problems.

Senator Breaux, you have been instrumental, whether you know it or not, in helping me to expose that at CMS. It was from some of the letters and correspondence that you had with CMS about oral health a few years back; so I had it down to thank you for that, actually.

We have submitted the actual new questions that will be in every chart across the country, which are going to be good questions.

Senator BREAUX. How do they differ from what the existing program requires?

Dr. FOLSE. The existing questions had the four main diseases—oral cancer, tooth-borne gum disease, and prosthetics—all mixed

into a bunch of jumbled questions, so when you tried to answer one, you had to look at three different things.

We separated out those four areas, and by separating them, we will be able to use some of the national data that we have about cavities and gum disease for the gum disease questions.

Also, again because of your efforts at CMS, we did the National Surveyor Training Session about a year and a half ago, where we trained the nursing home inspectors. It was pretty much based on the MDS, and the video from that has been dispersed—there were a lot of responses from our facilities across the country looking at oral health. They got this videotape, and they looked at it because they wanted to know what the surveyors were going to be looking for.

We are still pretty deeply involved in it, and special care dentistry has really been teaming up with ADA and CMS to have a real good result with that.

Senator BREAUX. Can Mr. Davis comment on that? That survey will indicate the potential problem that senior has coming into a nursing home.

Dr. FOLSE. Correct.

Senator BREAUX. It does not provide any treatment, but it at least recognizes that there is a problem.

Dr. FOLSE. Correct.

Senator BREAUX. Can you comment on the use of that data?

Mr. Davis. That data is collected on each patient, and it is actually collected in the nursing homes. It is expanded now. Dr. Folse spoke recently to a group that CMS participated in. It is a contracting group, and they are looking at this expansion of questions for a minimum dataset for dentistry. That is still under review. It is not finalized yet. But it is an expansion.

Senator BREAUX. That does not do anything for the patient. It is just sort of let us go to the wreck site and see how many people are hurt.

Dr. FOLSE. Correct.

Mr. Davis. Right. Surveyors used that as a part of their review. It is part of the things that they look at. They do look at medical records, and they do have interviews with the patients and with the families and with the staff, and they do have observation.

Senator BREAUX. Where does that MDS go?

Dr. FOLSE. If somebody has a cavity—the new question says, "Does the resident have a cavity?" If they check "Yes," that goes onto the care plan. Once it is on the care plan, they are supposed to refer that patient to a dentist or get appropriate care.

That is actually the way that it is supposed to happen now. The problem has been in the actual assessments. We have not had enough training to get those done correctly, and where I found 40 percent of my patients had a "Yes" trigger to the gum disease question, we found across the country out of 3.6 million MDS's 0.8 percent that were being triggered. So we were missing 39.2 percent of the population, according to my records.

Once that got exposed to CMS, they did make a commitment to us and to you to get the new questions and also to put in a quality indicator for oral health, which means not only will that information be used at the nursing home level; they receive all of those

data electronically, and if an individual facility would have, say, greater than 60 percent gum disease, or they would report less than 20 percent gum disease, it would trigger the quality indicator for oral health, which would let the surveyors inspect specifically for oral health issues.

Right now, the MDS questions are not tied to a quality indicator, so you can check them all of or you can check none of them off, and no survey question will come because of the MDS questions. So we are changing that.

Senator BREAUX. My next question was who makes that assessment. When you are admitting someone into a nursing home, is it a registered nurse, a practical nurse? Is it just an administrator who is on duty that night, who takes a look at the patient and says "Yes" or "No"?

Dr. FOLSE. In my facility, it is a range. Some facilities have licensed practical nurses do it; some have RN's do it. I have one facility—I do not go there anymore—where the social director was doing it, which was not that appropriate.

Having the training to get them up-to-speed will help. I think the way that we handled that broad case was "This is normal" and "This is abnormal." If it is abnormal, you check it, and you refer it. We tried to make it real simple, get out the big dental terms—that is not going to work.

The problem with the personnel who are doing it now is that every time they check this stuff off, they have to refer, and there is no infrastructure to refer them to. So it is a round-robin thing.

Senator BREAUX. Dr. Musher?

Mr. Musher. Yes, just a couple of comments. One, I can assure you that the MDS is taken very seriously in the nursing home, but I think it is more of the stick than the carrot is what you are hearing, and it is also data. I think what everybody is saying—and usually in facilities, it is an LPN, licensed practical nurse, not usually RN level, who is filling out this information—it is supposed to point out where we have concerns or problems to then lead into other things. It used to lead into what we called the RAPs, which were resident assessment protocols, or guidelines or other things—in other words, there may be a problem, how do we now approach that.

I think that is good, but I think what everybody is saying is that if it just becomes filling out the form and moving on, then we really have not accomplished what we need to accomplish. What we need to do is use that form as a guide, if you will, or a screen to say that we may have some problems, but we need to give the individual, whether it is the nurse or the other individuals in the facility, the education and the means to then go to the next step—because normally, as you are pointing out—and I have been pretty fortunate in most of my facilities to have dentists and dentistry available—but if there is a problem, I usually get the call. You are absolutely right—sometimes it is very frustrating to sit there and say well, I think there may be an abscess or a problem, I know the best treatment for an abscess is to take care of it, not just to treat with antibiotics—how do we then get to the next step?

Dr. FOLSE. I actually as the dental director in my facilities do the MDS for them, and that is one reason why I really like the dental

director model, because I am part of that process, I am part of the team.

Senator BREAUX. Yes, Daniel?

Mr. Perry. Thank you, Senator.

On one level, obviously, what we are talking about is the deplorable state of oral health in America, especially for our seniors. But just beneath the surface are two threads that are coming together. One is the thread of ageism which is endemic throughout the American health care system at all levels, where older patients tend to get fewer preventive treatments, less screening, fewer interventions than younger people would; and on the other end—and this, too, is part of ageism in our health care—is the failure of our professional health education schools to be able to provide some access to geriatric content for everyone who passes through them.

For those on the committee who may not know it, Senator Breaux has taken the leadership on both of these, and you and your staff are to be commended for full-scale hearings within the last 18 months, both on the shortage of academic training in geriatrics and on ageism.

I cannot offer today a simple solution to ageism, because it is part of our society; it is part of the fabric of who we are, and it has terrible effects on older people in health care. We ought to bring attention to it as you have been doing, Senator.

On the issue of greater envelopment of health professionals in their training in geriatrics, we can do something about that, and I am urging you and your staff to look at what we might do through HRSA to improve professional health education with geriatric content and most promising to create some department-level centers in our academic health centers where not only physicians and nurses and pharmacists, but dentists and all allied health professions, have to rotate and receive some of the basics in good geriatric care before they are out treating a patient population that increasingly is 50 percent age 60 and older in this country.

Senator BREAUX. I think that is a helpful suggestion, and I think we have heard a number of them. I am trying to figure out, if you had the ability to write a recommendation to the Congress and to the U.S. Senate as to how we can improve the quality of dental care for our Nation's elderly. I have heard the suggestion of the greater use of dental hygienists because of the shortage of dentists in many areas. I have heard the suggestion of trying to increase Medicaid coverage for the aged, blind, and disabled, at least move in that area with a limited amount of money.

Are there other suggestions that may be appropriate that we have not put down?

Paula.

Dr. FRIEDMAN. Thank you, Senator.

I have four recommendations that, with your permission, I would like to read into the record.

"One, broaden grantee eligibility for geriatric training programs. Dental education institutions currently may only compete for geriatric education center grants. ADEA recommends that grantee criteria be revised to include dental education institutions as the responsible applicant for the geriatric training for physicians, den-

tists, and behavioral/mental health professionals program. We further recommend that the criteria be broadened so that faculty members employed by U.S. dental schools are eligible to compete for geriatric academic career awards, which are currently limited only to physicians." While I certainly agree that we do not need to train a huge cohort of specialists, as you indicated earlier, we need to train enough to, as we call it, train the trainers, so that they can train general dentists and dental students.

"No. 2, authorize a new geriatric dentistry residency training program. ADEA recommends that a new Federal grant program modeled on the general and pediatric dentistry residency programs be authorized by Congress to prepare the dental workforce to meet the growing needs of an aging population." This might be a component of an existing general dentistry training program or indeed a second year added onto a 1-year training program in general dentistry with emphasis on geriatrics.

"No. 3, authorize a new NIH loan repayment program for research on the elderly and other special needs populations." I think that is self-explanatory.

"No. 4 and finally"—I believe this fourth one encompasses both an access issue and the fiscal piece that we all agree is an important component of geriatric oral health care, and that is "authorize a new reimbursement program for elderly dental care at academic dental institutions. Dental schools and their satellite clinics provide a significant amount of oral health care to the elderly. We are considered the safety net for people with limited fiscal resources. We cannot expand services beyond what is being done if Federal assistance is not made available to assist in paying for unreimbursed care."

Dr. Folse talked about the large degree that all dental schools certainly are providing in terms of unreimbursed care.

"ADEA urges Congress to authorize a dental reimbursement program for poor elderly obtaining treatment at the Nation's dental education institutions."

That certainly could include dental hygiene institutions. For your information, Senator—I imagine you know this, but just for the record—the fees at dental schools are generally a fraction of fees in private offices, so that a relationship with a dental education institution would be by extension a fraction of the cost of a private practice program.

Senator BREAUX. Those are good suggestions, and we would like to make sure we get a copy of that and the whole presentation.

Paul.

Dr. GLASSMAN. I think that in addition to funding and training systems, there needs to be a support system, and let me tell you what I mean by that.

We are just finishing up now a grant program that we have had in California. We have been working in eight communities around the State where we have had what we call a community-based system that is involved using people that we call dental coordinators. They are mostly dental hygienists, actually, who have played this role. Their role is to actually act as a liaison between the social support agencies that exist in every community that deal with the

special populations we are interested in and the dental professionals.

They do screening and triage; they get people into dental offices; they entice dentists to be willing to say "Yes" when they get a referral. They do preventive education.

I will give you an example of how it might work. Let us say you are a dentist, and you have a busy practice, and your practice is pretty full with people who can come in and pay full fare and sit in your chair and do not have a lot of complicated medical problems. So someone calls and says, "My mother has dementia. Can I bring her in to see you?"

You think, well, things are kind of busy, but sure, I want to do my part. So the person shows up, and you find that the daughter who brings the person in does not really know about their medical history or the medications they are taking, and their behavior is such that there is just no way you are going to treat them, and you spend a frustrating half an hour or 45 minutes trying.

The next time you get a call like that, what do you think you are going to say? You are going to say, "No, I really cannot do that."

Now picture situation No. 2. You have a dental coordinator in the community who calls up and says, "I have just done a screening on this individual. I was out to see them. I know your office because I have talked with you before, and I know the kinds of things that you are able to do in your office, and I think this person would work pretty well in your office. When they get there, I am going to make sure that you have all the medical history information you need, and we are going to take care of the consent issues, because I am going to work with the social service agency who knows how to get consent."

When the person gets there, they are going to have the medical history, the consent is going to be taken care of, they are going to be matched to the dental office. Now, the chances of that referral being successful are infinitely better than the first one.

So in that kind of program, our 3-year results are now showing that people have significantly less dental disease. There are numbers of dentists in these communities who are now willing to say yes under the circumstances I just described who were not willing to say yes before. In fact, the amount of dental disease in the population we are talking about, the burden of dental disease, the cost of providing treatment for that dental disease has gone down to a degree that it is more than the salaries that we are paying to these dental hygienists who are providing these services.

So I think there needs to be a support system that goes along with funding and training.

Senator BREAUX. So your suggestion is—are you trying to do this in California, or——

Dr. GLASSMAN. We are just finishing up a 3-year demonstration and demonstrating the effects of this, and we are showing great results.

Senator BREAUX. So is there a dental coordinator for seniors?

Dr. GLASSMAN. We picked eight communities throughout the State. We have a dental coordinator who works with social service agencies in those communities and plays this role of acting as a liaison between these agencies and the dental community, helps to

bridge the gap, helps to make the kinds of referrals that we talked about, does preventive education and preventive programs, does screenings and gets people into care.

Senator BREAUX. A good idea.

Jim.

Dr. HARRELL. The only thing that would worry me is that in North Carolina, we have a shortage of dental hygienists, so I cannot tell you where you are going to get them—do not take them from my office.

Also on the manpower issue, as I said, we have studied that, and the term "shortage" has been used a couple of times. I do not know—and there again, the data is kind of squirrely—but I do not know that we have a shortage, but we definitely have a maldistribution.

I think the Surgeon General mentioned diversity of the dental work force. The University of North Carolina is starting to give preference to students from rural areas, hoping that they will return to rural areas when they graduate, because they tend to go to the metropolitan areas. So it is hard to know, but I do not know that we definitely have a shortage.

Senator BREAUX. We have had some good suggestions, and this is the first thing that we have ever focused on a particular problem area of seniors in terms of a disease. We have held hearing on senior problems with people who were scamming them from an insurance standpoint, people who discriminate against them in the job market, actual care and treatment that they get in nursing homes, and have looked at alternative means of caring for seniors. But I think this is really the first time we have actually had a discussion on a particular ailment of seniors that has not been noticed as much as it should or treated as adequately as it could be. I think it has been very helpful to do this, because this really is sort of a silent illness out there that people are ignoring, and it leads to much more serious problems, much more expensive problems, and a lot of suffering that in many cases is unnecessary in today's society.

The question is how do we go about trying to fix it and how do we go about trying to solve it. We have gotten some good suggestions on the table, and I would like to see if anybody has any closing comments, perhaps, to help us summarize.

I want to try to bring the information we get from here to maybe do some statements on the floor of the Senate to try to get some other Members interested in this, because when you find out that most States are not doing a very good job of paying attention to the oral health of our Nation's seniors within their States, it is a serious problem, and it should not go neglected as we have neglected it in the past.

Does anybody have any final suggestions that may be helpful?

Robert.

Dr. COLLINS. Thanks, Senator.

This has been a wonderful hearing. There is an awful lot of information that is out there, and many people around this table and others have had an opportunity to contribute to that. I think this is one more step in the Surgeon General's Call to Action booklet

which he kind of modestly talked about today, but I think is increasing the involvement of a larger community of people.

I had a mentor as I came along in public health who used to talk about ERAs of expectation in regard to oral health. The first one, which I guess covers a large portion of history, was resignation. You had pain, and you just found out a way to deal with it, and maybe you had somebody who could relieve it by knocking your tooth out.

We went into a second period of rehabilitation where you had dentures available, crude in the beginning, more sophisticated as time went on, where people could still expect to lose all their teeth, but now they had some sort of replacement.

The third era, which we are really still in and coming out of as a whole is the restorative area. These are the 77 million that you are talking about in your question, people who have a lot of complex dentistry who are moving into older age.

The final era is one of prevention.

So, we have some conflicts here with people who are in an era where they are beginning to expect that a lot of these problems that Dr. Folse so nicely illustrated today should not be there—they should be prevented. We have research that can go a long way toward pointing the way to do that, yet we have a system that I would say in many cases is not even in rehabilitation in terms of responding; it is back in resignation.

So there are lots of ways that we can point forward to the future, and I just wanted to underscore my appreciation and support not only for what the Surgeon General is doing, because I think that is a terrific, terrific booklet, that little green booklet, but also for all the Federal agencies, in particular the National Institute of Dental and Cranio-Facial Research—yes, it does support a lot of research in universities and across the country and funds most of the dental research and is therefore very important, but it also serves as probably the principal coordinating center in the Federal infrastructure for oral health and makes it possible, I would say, probably if you go back to the beginning, possible for all of us to be here today.

Thank you.

Senator BREAUX. Thank you.

Ms. Heinrich, do you have anything from General Accounting?

Ms. HEINRICH. I really do appreciate the opportunity to hear all of these ideas. It really is very thought-provoking.

I appreciate your point that there are several ways of focusing on this problem, and one question I had was with the focus that we have put on prevention with children—fluoridation, for example—do we anticipate that this problem is going to wane in the future?

A second question—Paul, you have talked about some best practices in California; there might be some in New York also, since they got a C-plus—but has there been any effort to identify strategies that really do work in trying to bring better dental care to older populations?

Senator BREAUX. Let me interrupt. I am going to have to take off. But Janet, why don't you all finish up on this question, and let me just conclude for my part and thank each and every one of you.

I think it has been very important, and we have gotten some good ideas.

To those who have travelled, thank you, Greg and others who have come from other places, for being with us. It was well worth your effort as far as I am concerned. I am very appreciative of the information that we have been able to learn and the suggestions that we have received.

So I thank you all, and please continue.

Dr. FOLSE. Before you leave, we thank you very much. [Applause.]

Dr. GLASSMAN. Just to respond to the question about best practices, yes, I think there are a number of publications and articles and lots of information about best practices. The problem is that the best practices, the theoretical ones, the ones that have been used in demonstration projects, are not widely available and not widely used because of the issues we have already identified here—awareness and funding and training.

So the best practices do exist. The American Association of Geriatric Dentists has a number of publications about guidelines for nursing home dental practice. There are guidelines in other areas. The next issue of the Journal of Special Care Dentistry is going to have the results of an expert panel that we brought together to look at prevention in disabled and elderly populations.

So I think the information is there. The problem is taking that information and translating it and getting it into practice is where there is a gigantic chasm.

Ms. HEINRICH. In terms of Senator Breaux' interest in having material that people could speak to, are there some of those that would have information about dollar savings or costs that could be provided to Members of Congress?

Dr. GLASSMAN. I am not aware of that. I do not know if others are.

Dr. COLLINS. I pointed out earlier that one of the things in the Surgeon General's report on Oral Health in America is that it states in that report the lack of data about both the oral health burden and strategies and all those things, and we all wish we had numbers about those kinds of things. The numbers are generally not available, unfortunately.

Dr. FOLSE. Dr. Barsley actually did a study in Louisiana for Medicaid children where they used some interventions, and there were significant savings with just water fluoridation for that population.

Dr. Barsley.

Dr. BARSLEY. For children with fluoridation, we showed the parishes or counties that were fluoridated had significant savings over the counties that were not. Does that translate to the adult population? I am not sure.

I would break in and answer one question—I do not see this problem waning at all. As people have better teeth and better lives, we are going to have a bigger problem. So I do not see any waning of the problem in any way at all; it will just continue to grow.

Ms. HEINRICH. Paul, and then James.

Dr. GLASSMAN. I just want to emphasize that point, that the problem is not going away. We have gone from in our country 20

years ago, I think it was something like 56 percent of people over 65 being in dentures; now it is down to about 26 and dropping. So we are having more and more seniors who are becoming seniors with teeth that did not used to have that, and the fact that disease for certain groups of children is going away does not really have much impact on what happens when people get to be 65 and can no longer care for themselves the way they used to and begin to take medications and have dry mouth. So I think this is going to be a blossoming problem.

Ms. HEINRICH. Teresa.

Dr. DOLAN. I would just add that I certainly agree that this problem will not go away. It is a good news/bad news story, because as the younger cohorts of adults age, and we have retained their natural teeth—maybe we have had some dental fillings—but we also have higher expectations, and we are more vocal about our expectations, I think as those folks become chronically ill and perhaps end up in long-term care facilities, the demand for a more appropriate level of oral health services will grow, and if anything, the cost associated with that will increase. I think that what is currently a silent epidemic will become more prominent.

Ms. HEINRICH. Go ahead, James.

Dr. HARRELL. As we have a unique program in North Carolina, I will try to get any data on cost-sharing that the ADA has for you. I am not sure what we have.

We do have an interesting program in North Carolina where we have physicians apply fluoride varnishes. We are doing studies on that, and I do not know the results at this point or whether that will be a cost saving or not; we suspect that it will. The problem was that by the time these children were seeing a dentist at 2 or 3 years of age, they already had decay.

The American Dental Association has been sort of reeling with the punches and doing what we can to boost the Medicaid reimbursements or whatever. We are having a Medicaid symposium in December, which will hopefully be a small group similar to this one, to actually look at the whole system and maybe come up with some innovations for that system.

Also, thinking about Paul's remarks, we have a van program which is mostly a nonprofit organization in North Carolina, but I do not want us to overlook the fact that there are multi-millionaires in nursing homes who cannot get care because they have special needs, and they require treatment that they do not have the facilities to do—even if they can bring them to my office, I cannot do it. So I do not want us to overlook that segment of the population either.

Ms. HEINRICH. Senator Breaux was beginning to ask all of you for recommendations on solutions to this problem, and not all of you had a chance to speak, so I would ask if there are other ideas.

Mr. Musher. Just a couple of points—I guess some things that we could do now, not to lighten the big, 10,000-foot view—but there are certain initiatives going on now. For example, there is a pain initiative. There is a collaborative initiative that CMS is part of concerning pain and trying to develop best practices. Certainly oral pain problems and syndromes could be better focused on through that.

So I think there are certain programs that are going on. The American Medical Directors' Association has created many guidelines. That could certainly be something that would lend itself toward a guideline on how do you approach oral care in the nursing home.

Again, not lightening the access to care, which is what I hear is a huge issue, and my frustration, as I mentioned earlier, is trying to get a dentist or a dental surgeon or extractions or certain things that I may need at some points in time, but I think there are areas where we could use some of the systems or some of the approaches that are now available to just better point out the need for oral care.

I know that like no other industry—in the nursing home, if you focus on something, there is a very good likelihood of it happening, especially when you connect it with MDS and other survey issues. But I think that a lot of what I am seeing is if we could just get the word out that oral care is something that is urgent and important, just like we did several years ago with restraint reduction—there was a huge decrease in restraints once we put it back on the providers of services to say this is a huge problem, we need to work together to solve that problem—and we did, and I do not think there was a huge cost to that.

So although there are a lot of costs and issues that we have talked about that I don't think lend themselves to that, I do think at least some focus on how we would approach oral care in nursing homes is important.

The other point I would like to make—and it is no different from what we struggle with in other parts of medicine with our population, and I will use high cholesterol as an example. We do not treat everybody who has high cholesterol in the nursing home population because it is risk-benefit and it is quality of life issues. So at some points, I think we also have to look at what should we be treating and what do we not necessarily have to treat. The Senator mentioned earlier about whitening teeth. I am not really worried about cosmetic issues in a lot of my patients. I am not sure—and I would defer to my dental colleagues—whether I have to worry so much about dentures, because I was taught that a lot of my patients could actually gum their food. So I am not sure that dentures are as important as pain, abscess, xerostomia, which I have seen huge problems with. So how do we focus—the pain, the abscess, those kinds of things in my severely demented patients are a quality of life issue, so I would want to focus on the quality of life issue, but I think we have to break down the population, because the nursing home has dementia and end-stage and almost palliative types of care, but there are all other subsets of elderly in our population.

Ms. HEINRICH. Yes?

Dr. BARSLEY. If I could add one thing that I do not think has been addressed, or only on the margins, it would be to increase interaction and educational interplay between physicians and dentists.

I used to teach at the medical school and give lectures on dental health to medical students. They were amazed at what we brought them. Then we would bring them out to our clinic and have them

actually look into each other's mouths, and they were further amazed by what was in the mouth besides the teeth.

So I think if we start at an early time and broaden that, we would be benefited.

Ms. HEINRICH. Karen.

Ms. SEALANDER. I think that the mere holding of this forum is an important signal that this committee, and hopefully the whole Senate, thinks that oral health is important. Hopefully in the future, whenever Senators think of seniors' general health, they will think of oral health as well.

We know how to prevent the principal oral maladies, and despite this proven prevention capacity, we still have this silent epidemic of oral disease which disproportionately affects our vulnerable citizens, particularly the elderly. ADH wants to be part of a collaborative solution to the problem of oral health disparities and inadequate access to care. ADHA believes that with the increasing number of hygienists, the occupational growth, and with our focus on prevention that dental hygienists are well-situated to play an important role.

One specific suggestion that ADHA offers is to ask the committee to direct CMS to write to State dental directors, asking them to facilitate the provision of Medicaid oral health services by hygienists, specifically to recognize hygienists as Medicaid providers of oral health services. Ten States already do recognize hygienists as Medical providers and ADHA would like to see the other 40 States follow suit.

Ms. HEINRICH. Anyone else?

Dr. FOLSE. A couple of comments in closing for me. In nursing facilities, I think there is an obvious partner there. Some of the efforts that we have made have been along survey issues, and I just want to assure you that that is not my focus in my advocacy efforts and the work that I do with ADA and special care dentistry. It is not about coming in with the hammer; it is about we had that opportunity, so you go there. But at the same time, we are doing all kinds of things to help bring that industry up with oral health, working with the American Medical Director Association. I and special care dentistry for sure are seriously committed to working with your industry trying to help in any way that we can. We have education programs all day long that we can help you with.

Your point about not treating everyone is really well-taken. I have patients with really bad oral conditions who, because of the risk-benefit issues, I say we are not going to be able to take care of these patients. So I am with you there—education—we can all come to consensus with that.

Again going back to a foundation medically is the medical necessity of oral services. I still think it is a medical necessity.

Does anyone have disagreement with that? [No response.]

So one of the things that we could say from this forum—or can we—is that we were all in agreement that oral health services for vulnerable adults was medically necessary.

Are there any nays? I do not see any. OK. My dad was an auctioneer.

Dr. HARRELL. Actually, I would modify that and leave out the "vulnerable adults." Oral health care is essentially the general health for anybody.

Dr. FOLSE. Thank you. I limit myself unnecessarily sometimes.

I think in these State budgetary woes that everybody has, if they would find their State problem and find some things that they did not want to pay for, all they have to do is put a set of lips on it. Once you get behind some lips, it does not get any money, so it seems like it would help somewhere along the way.

Personally, I have been involved with this forum, and we have to thank Lauren Fuller who behind the scenes has done an awful lot of work for the last 3 or 4 months, has taken endless calls from Dr. Greg Folse—she probably does not want to hear from me for 6 months, and even then, I am not sure—but we really thank you for your work and your dedication to oral health for elders across the country. You have started something here, and it is going to be a fun ball to watch.

Before I let you close this, I want to thank each and every one of you again for being here and participating, and those of you in the audience who really care about oral health services for our elderly, I thank you for being here also.

Ms. HEINRICH. Well, I think you did a very nice job of closing. I think it is easy to say that you have put information together in one place, and yes, it is going to be interesting to see how this moves forward.

Thank you all.

[Whereupon, at 4:05 p.m., the forum was concluded.]

A P P E N D I X

Testimony of

Daniel Perry
Executive Director

Alliance for Aging Research

The Senate Special Committee on Aging

September 22, 2003

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Chairman Craig, Senator Breaux and distinguished members of the Special Committee on Aging, thank you for this opportunity to address the prevalence of ageism in American healthcare and it's regrettable effects on the health of older Americans. Today you are looking into oral health services for seniors and again we see the effects of passive neglect that is ageism pure and simple.

Senator Breaux, last May you presided over a hearing of this Committee, which raised awareness about the systemic bias against older people in American health care. The hearing focused largely on the growing dearth of geriatric trained healthcare providers and the widening gap in access to appropriate care for America's fast growing population of older adults. Today's hearing highlights how the lack of adequate geriatric training among the nation's health care providers, coupled with the systemic age-related bias of the American healthcare system, puts at risk the oral health of millions of older people.

The not-for-profit, Alliance for Aging Research works to ensure that older Americans receive quality healthcare, and have access to the newest and most effective medications, treatments, therapies and medical technologies, without any discrimination based on age.

In the Alliance for Aging Research's May 2003 report, ***Ageism: How Healthcare Fails the Elderly***, which we presented to this Committee, we documented how older patients too often do not receive preventive treatments such as vaccines and screening tests that could

potentially prevent diseases from becoming life threatening. This issue is even more acute in geriatric oral healthcare, where several diseases first appear in the mouth and often go unnoticed by periodontal professionals untrained to meet the specific needs of older patients.

Ageism is a deep and often-unconscious prejudice against the old, an attitude that permeates American culture. It is a particularly apparent and especially damaging frame of mind that surfaces all too often in health care settings. Like other patterns of bias – such as racism and sexism – these attitudes diminish us all, but they can be downright deadly to older people in receiving health care.

Older people have medical needs far different from younger adults. On average, most people aged 75 and older have three chronic medical conditions or ailments that require more than four prescription medications at any given time. Comprehensive care of any dental patient requires knowledge of their signs and symptoms, their role in the clinical spectrum of general diseases and conditions, and the most appropriate means to manage their care.

Research supported by the National Institute of Dental and Craniofacial Research continues to show strong connections between one's oral health and risk of systemic disease. The mouth and face can be likened to a crystal ball, predicting diseases and conditions yet to come. Many early warning signs of cardiovascular disease, osteoporosis, diabetes, and cancer can be detected in the health of our teeth, gums, and mouth before they are seen elsewhere in the body.

Without a properly trained geriatric dental workforce, many elder Americans who display symptoms common to many serious diseases often are misdiagnosed, improperly treated, or go completely undiagnosed. I quote from an article that appeared in the May 2003 issue of Journal of Dental Education, "…while teaching in geriatric dentistry has progressively

increased over the years, a significant proportion of graduating dental seniors recognize that they have been insufficiently trained in this subject and feel unprepared for practice." And, unfortunately the lack of geriatrically trained dentists is equal or more severe for every other health profession – physicians, nurses, pharmacists, and others. This is a serious disconnect that will grow worse unless policymakers and stakeholders take action to address the critical shortage of geriatric health care professionals.

So many unprepared dental providers leaves the profession ill equipped to deal with the oral healthcare needs of America's aging population, which will double to over 70 million by 2030. Already, some 6000 Americans turn age 65 every day in our country and will grow to 10,000 a day by 2011, representing a growing population that according to the National Institutes of Health is seven times more likely to be diagnosed with oral cancer than those who are younger.

The absence of adequate exposure to the principles of good geriatric medicine during professional training can additionally foster ageist assumptions that "it's too late" to change the health habits or older people, or worse, that serious and chronic health problems in older patients are a "natural" and therefore acceptable part of the aging process. The bias that underlies these shortcomings would be unacceptable if the elderly were a small percentage of the patient population in our country, but by 2030 almost 1 in 4 of the entire population of the U.S. will 65 and older. Ageist assumptions that distort the quality of health care for such a large and growing group hurt everyone, because they lead to premature loss of independence on a giant scale, and they increase mortality, disability and depression in older adults who might otherwise lead productive, satisfying and healthier lives.

Medical neglect of the aged often begins even before illness strikes. Many older Americans are given few options when it comes to access of oral care due to their general lack of dental insurance, which is lost for most at retirement, and the absence of coverage under Medicare for basic oral health. Yet, older Americans are most likely to be diagnosed with potentially deadly oral health problems – mouth and throat cancers – than any other group. This combination of inadequate oral health care insurance – reducing access – coupled with the general absence of geriatric training on behalf of the of health professionals, produces a dangerous double whammy to the health of aging Americans.

New models are needed to reform our country's medical, dental, and health care professional education. Every doctor, dentist, nurse, and allied health provider should receive some training in geriatrics prior to graduation. The Alliance envisions special departments or centers of geriatric medicine that will offer interdisciplinary research and training in geriatrics – arming our future health care providers with the necessary skills to properly evaluate and treat older patients. Additionally, we must also recognize that until we realize a more effective mechanism of oral health care insurance for America's older population, many of the challenges to proper geriatric oral health will continue to persist.

Mr. Chairman, the Alliance for Aging Research thanks the Special Committee for its attention to ageism in oral health care. Ageism is not something that we can just accept or ignore, and unfortunately, and it is not something that will just go away. This is a problem that needs strong leadership to develop novel solutions that will elevate and integrate geriatric training in America's medical and dental schools to create a broad based population of health professionals armed with the proper clinical knowledge to meet the needs of older Americans. Thank you.

Statement of Dr. Robert Collins

Written Statement of the American Association for Dental Research (AADR)
Senate Special Committee on Aging Forum: ***Ageism in Health Care: Are Our Nation's Seniors Receiving Proper Oral health Care?***

The AADR is a nonprofit organization composed of nearly 5,000 individual members and 100 institutional members dedicated to advancing research to improve oral health and facilitating the communication and application of research findings. AADR is a full partner with the US Department of Health & Human Services in addressing the Surgeon General's Call to Oral health Action and the Healthy People 2010 oral health objectives. To this end, the AADR in 2003 signed a Memorandum of Understanding (MOU) with the US Department of Health & Human Services in which the AADR agreed to engage in activities designed to facilitate the achievement of the oral health objectives of HP 2010 related to the prevention of dental caries, periodontal disease and the early diagnosis of oral cancer.

The AADR appreciates the opportunity to present its views and recommendations on the topic of oral health and aging to the Senate Special Committee on Aging. The following comments follow the order of the four questions that the various groups invited to the Forum have been asked to address.

1. What are the greatest problems that America's seniors face where oral health is concerned?

The major problem for older adults is the age-associated increased risk for disease – especially chronic diseases – and the likelihood that there will be multiple co-morbid conditions. Many of these diseases and their treatments (medications), place them at greater risk for oral health problems.

Currently, 35 million people are over age 65 in the United States, and this number is expected to double to 70 million by 2030 when one in five Americans will be 65 years or older. Women who reach age 65 can expect to live an additional 19 years of life, while men can expect to live an additional 16 years. The gap in life expectancy between men and women is narrowing with improvements in medical care, preventive health services and healthier lifestyles.

Disability from chronic disease places older adults at greatest risk for oral disease. More than half of older adults report at least one physical or non-physical disability. Disability is more severe in the very old. Arthritis occurs in half of older persons and can have a profound effect on oral hygiene. Older adults' more frequent use of medications such as antidepressants, antihistamines, antihypertensives and diuretics is often associated with decreased saliva flow, xerostomia, or dry mouth. Reduced salivary flow compromises the ability of the elderly to chew, speak, taste, swallow and increases the risk for dental caries, periodontal diseases, and soft-tissue trauma. Oral candidiasis (thrush or an oral infection caused by yeast) may occur with long-term use of antibiotics, steroid therapy or chemotherapy. Gingival overgrowth also can be induced by medications such anticonvulsants (phenytoin), cyclosporine and calcium channel blockers (e.g., nifedipine) in the presence of poor oral hygiene, further complicating the ability to maintain good oral hygiene. Medical conditions that compromise the immune system such as diabetes

mellitus, head and neck radiation therapy and human immunodeficiency virus (HIV) infection also place the patient at risk for candidiasis.

Dental caries is not just a problem of the young. Older adults not only experience cavities on the crowns of the teeth like young people, but they are also more likely to have root caries. Root caries occurs more frequently in older adults. Until recently dental caries was considered a childhood disease; however, older adults present with the greatest increase in the number of teeth at risk for caries. Estimates show that by 2030 the number of teeth at risk for dental caries in 45-64 year olds will increase by 73% and in the 65-84 year old group 104%. This increase is due to the fact that people are living longer and with more of their teeth. National survey data show that 47% of individuals age 65 to 74 and 56% of individuals 75 years and older have decayed or filled root surfaces. Risk factors for root caries are dry mouth, poor oral hygiene, exposed root surfaces (gingival recession), cognitive or physical deficits, a high carbohydrate diet and partial dentures.

Little evidence exists that the risk factors for periodontal disease in older adults are different than the risk for factors for younger people. Nonetheless, periodontal disease in older adults may be modified by health and immune status, medication, genetics, diabetes, nutrition, saliva flow, as well and cognitive and functional deficits. Regardless of age, periodontal disease may progress faster and the response to its treatment may be slower in smokers than non-smokers.

Tobacco and alcohol use are the major risk factors for oral and pharyngeal cancers. Approximately 90% of people with oral and pharyngeal cancers use tobacco. All forms of tobacco use, including smokeless/chewing, cigars, and pipes, increase the risk for the disease. Smokers and those who frequently drink alcohol are up to six times more likely than who do not use these products to develop oral cancers. It is estimated that oral and pharyngeal cancer will account for 28,900 new cases and 7,400 deaths in the 2002 in the US. Oral and pharyngeal cancer increases with advanced age with most occurring after age 40. Men are diagnosed with the disease twice as often as women although data suggest the gap is slowly narrowing. The prognosis for oral and pharyngeal cancer has not improved in recent decades and more than half of oral cancers have metastasized to a distant site by the time of diagnosis.

Oral diseases such as dental caries, periodontal disease, oral cancer, and other soft tissue lesions are often present in older adults. Compounding the occurrence of oral disease are medical and psychiatric diagnoses, as well as physical and financial limitations.

- Although edentulism has declined in the elderly from 46% in the early 1970s to 29% in 1988-94, those with lower incomes are much more likely to be missing all their teeth. 37% of those with incomes of <$15,000 are edentulous compared to only 8% of those with incomes greater than $50,000. Further, irrespective of income, the percentage of the population with a "functional dentition" (at least 21 teeth) declines with age as illustrated below. The use of dental services by the elderly is correlated not only with income and dental insurance coverage by also by the presence of teeth. As the edentulous population continues to decline and is replaced by older adults with increasing numbers of teeth requiring large amounts of restorative care, the need and demand for dental care by the elderly can be expected to grow.

Age	% with at least 21 teeth
20-29	97
60-69	41
7079	30
80+	28

- On average, healthy community dwelling seniors take 3-4 medications per day compared to those in long-term care facilities who take about 8 medications per day. Many prescription and over-the-counter medications are associated with decreased saliva flow, and dry mouth and can, therefore, compromise chewing, tasting speaking and swallowing. (Niessen, Fedele 2002)
- It has been estimated that about one-third of community-dwelling older adults may have xerostomia and often patients are asymptomatic. Assessment of salivary flow is not usually incorporated into a routine dental examination; however, as noted above, lack of adequate saliva can be a significant problem for the elderly. Available clinical resources are now directed toward restorative dental treatment rather than specific diagnosis of the problem and implementation of an aggressive preventive intervention. (Navazesh, 2002)
- It has been reported that seniors are now entering nursing homes with greater numbers of teeth as well as more complex dentistry such as implant-supported prostheses. (Niessen, Fedele 2002)
- Data from the third NHANES indicate that 47% of 65-74 year olds and 56% of 75 year olds had decayed or filled root surfaces. (Winn, 1996)
- Although caries risk has declined for children and young adults, it has not done so for those 45 and older and in fact has increased for those 70 years and older. Caries risk management is especially important for the elderly population, given the additional risk factors, such as gingival recession, decreased salivary flow, removable partial dentures, physical disability, inability to pay for treatment and limited access to dental care. (Anusavice 2002)
- Few randomized controlled trials have been conducted to assess changing risk patterns for caries in the elderly or identify optimal diagnostic and treatment approaches to reduce caries risk. (Anusavice 2002)
- Only 7% of 75-85 year olds have healthy periodontal tissues (Mulligan, 2002).
- Lack of manual dexterity and/or visual acuity may hamper efforts of the elderly in performing oral hygiene. Dementia in institutionalized elderly further complicates plaque removal. (Mulligan, 2002)
- Two-thirds of oral and pharyngeal cancers occur in the elderly. (Mulligan, 2002)
- Other risks to the general health of the elderly that may be related to oral health include aspiration pneumonia and cardiovascular disease. Additional studies are needed in order in to determine the most effective preventive regimens for aspiration pneumonia and to determine if there is in fact a causal link between periodontal disease and cardiovascular disease or low birth weight babies. (Page et al In: Annals of Periodontology, 2001)
- About 60% of women and 50% of men 70 and older have osteoporosis (Sarment, 2002) and as individuals continue to live longer, the prevalence of osteoporosis is expected to increase rapidly. Limited research shows a correlation between bone mineral density

(BMD) of the jaws and systemic BMD. If supported by additional research, it is possible that dental x-ray films could eventually be used as screening devices for osteoporosis. Further studies of the relationships between osteoporosis, periodontal disease and tooth loss offer the opportunity to improve both the diagnosis and treatment of all these conditions. (Mulligan, 2002)

2. Caring for the elderly necessitates a multi-disciplinary approach. What are the responsibilities of the various stakeholders in providing older Americans with proper dental care?

A major challenge in caring for older adults is managing the multiple existing co-morbid chronic conditions whose course and treatment may introduce further problems and complications. Geriatric caregivers must appreciate the potential scope of potential interactions. There are a number of diseases and conditions that place older adults at greater risk for dental and oral health problems. Conversely, due to senescent and disease-related alterations in immune competence or neurological impairment, oral disease may present a significant risk to the general health of selected populations.

From the perspective of the research community, we believe significant advances have been made that have directly contributed to improved oral health for older Americans, but much remains to be done. Many advances in dental disease prevention and treatment have been made possible through dental research. Prevention of tooth decay has been enhanced by studies revealing the benefits of water fluoridation, fluoride rinses, toothpastes, and varnishes as well as dental sealants. Treatment of the effects of tooth decay range from vastly improved restorative materials to implants to replace lost teeth. Scientists are exploring connections between periodontal and systemic diseases and biomimetics offers the potential to eventually grow new teeth (Young, 2002). Remarkable advances in human molecular genetics are identifying genes for developing therapeutic approaches to many oral diseases, including those that affect the elderly (US DHHS 2000). It is important to continue to support this ongoing research to enhance the prevention of disease and the effectiveness of care delivery. The AADR encourages support of federal agencies (NIDCR, AHRQ, CDC, DoD, VA) that are engaged in this research and notes the following as highlights of areas of opportunity for future research.

- Continue research efforts in risk assessment for oral disease. Encourage the development of practice-based networks to further refine these tools.
- Encourage the NIDCR and other federal agencies to support research efforts to identify the most appropriate methods of addressing the oral health needs of seniors.
- Support research that will determine whether or not there is a causal link between periodontal disease and cardiovascular disease, or aspiration pneumonia.
- Support research to advance the use of saliva as a diagnostic fluid for a wide variety of conditions, such as diabetes and breast cancer.
- Expand support for the NIDCR Centers for Research to Reduce Disparities to better understand the complex interplay among factors such as socio-economic status, ethnicity and environment.

- Support research efforts to improve the diagnosis of and expand treatment options for temporomandibular joint disorders.
- Support biomimetic and tissue engineering research that may eventually allow for the replacement of lost tooth structure with natural body tissue or even the ability to stimulate the growth of new teeth and perhaps functional structures of the periodontium as well.

3. Are there sufficient numbers of properly trained geriatric dentists, especially as 77 million baby boomers prepare to retire?

No. It is essential that geriatric dentists be trained in an interdisciplinary and multidisciplinary environment of health providers to appreciate the scope of diseases and health impacts of co-morbid conditions.

In preparation for this Forum, the AADR was unable to locate data on the number of dental practitioners specifically trained in geriatrics. Given the risk factors identify earlier, it certainly makes sense to have dental clinicians who are fully aware of the risk factors and are equipped with the necessary diagnostic and treatment skills. To achieve this goal, however, it may not be necessary to train large numbers of geriatric dental specialists. Such skills should be imparted as part of the didactic and clinical training received in dental school, with supplementation available through general practice and advanced dental education residencies. There should also be a number of residency programs in geriatric dentistry for practitioners who wish to devote their practices to treatment of the elderly and to train the needed faculty in this area. It is noteworthy that, despite the inexorable 'graying' of the US population, dental geriatric residencies in the Veterans Administration, once a key source of acquiring skills in this field, have been eliminated.

4. Suggested Solutions and/or Recommendations

- Support a research agenda that uncovers the causes of oral disease in older Americans and identifies best treatment options.
- Engage as many stakeholders as possible in pursuing the Surgeon General's *Call to Action to Promote Oral Health.*
- Use the *Healthy People 2010* Oral Health objectives to guide and evaluate efforts to improve oral health for senior citizens
- Implement aggressive prevention efforts, using evidence-based interventions for patients determined to be at high risk for oral diseases whether in community or institutional settings.
- Improve the financing of oral health care for the elderly. Among the options to be considered: coverage of basic dental services under Medicaid, extending private dental coverage into retirement years, or providing seniors with the option to pay modest premiums for private coverage of a basic package of dental services. At a minimum, implement the recommendations of the IOM in regard to medically necessary dental services.
- Assure that dental schools, residencies and continuing education offer training that will enhance the knowledge and skill of providers in addressing the needs of seniors.

5. Selected References of Interest:

Agency for Healthcare Research & Quality. *Research in Action: Dental care: improving access and quality.* AHRQ Pub No. 03-0040. July 2003
American Academy of Periodontology. *Proceedings of the periodontal-systemic connection: a state-of-the-art symposium.* AAP and the national Institute of Dental & Craniofacial Research. Vol. 6, No. 1, December 2001.
American Association of Public Health Dentistry. *A research agenda for dental public health.* J Pub H Dent, Vol. 52, No.1, Spcl issue 1992.
American Dental Association. *Future of dentistry.* Chicago: American Dental Association. Health Policy Resources Center: 2001
Anusavice KJ: *Dental Caries: Risk assessment and treatment solution for an elderly population.* Compendium 2002; 23 (Suppl) 12-20.
Brown LJ, Brunelle JA, Kingman A: *Periodontal status in the United States, 1988-1991: prevalence, extent, and demographic variation.* J Dent Res 1996; 75 (Spec No): 672-683.
Dental, Oral and Craniofacial Data Resource Center. *Oral health U.S., 2002.* Bethesda, MD: 2002.
Institute of Medicine. *Extending Medicare coverage for preventive and other services.* National Academy of Sciences. National Academy Press. Washington, DC: 2000.
Institute of Medicine. *Dental education at the crossroads.* Committee of the Future of Dental Education. National Academy of Sciences. National Academy Press, Washington, DC. 1995
Locker D, Slade GD, Murray H: *Epidemiology of periodontal disease among older adults: A review.* Periodontology 2000. 1998; 16:16-33.
Mulligan R. *The three phases of eve: exploring the common and unique findings in oral and systemic health of differently aging women.* Compendium 2002; 23.10 (Suppl) 32-40.
Navazesh M. *Dry mouth: aging and oral health.* Compendium 2002; 23.10 (Suppl) 41-47.
Niessen LC, Fedele DJ: *Aging Successfully: Oral Health for the Prime of Life.* Compendium 2002; 23.10 (Suppl) 4-11.
Sarment D, Antonucci T. *Oral health-quality of life and older adults.* IN Inglehart M, Bargramian R (eds): Oral health-related quality of life. Quintessence books: 2002.
Oral Health America. *Keep America smiling- the oral health America grading project 2003.* Chicago. 2003 www.oralhealthamerica.org
Reddy M. *Oral osteoporosis: is there an association between periodontitis and osteopororsis?* Compendium 2002; 23.10 (Suppl) 21-28.
Silverman Jr. S: *Demographics and occurrence of oral and pharyngeal cancers: the outcomes, the trends, the challenge.* JADA 2001; 132 (Suppl) 7S-11S.
US Department of Health & Human Services. *Oral health in America: a report of the Surgeon General.* Rockville, MD: Department of Health & Human Services, National Institute of Dental & Craniofacial Research, National Institutes of Health, 2000.
US Department of Health & Human Services. *Healthy people 2010.* (conference edition) January 2000. www.health.gov/healthypeople
US Department of Health & Human Services. *A national call to action to promote oral health- a public-private partnership under the leadership of the Surgeon General.* NIH Pub No. 03-530, May 2003.
Winn DM: *Tobacco use and oral disease.* J Dent Ed 2001; 65(4): 306-312.
Winn DM, Brunelle JA, Selwitz RH et al: *Coronal and root caries in the dentition of adults in the United States, 1988-1991.* J Dent Res 1996; 75 Spec No: 642-51.
Young CS, Terada S, Vacanti JP, Honda M, Bartlett JD, Yelick PC (2002). Tissue engineering of complex tooth structures on biodegradable polymer scaffolds. *J Dent Res* 81:695-700, 2002.

Statement
of the

American Association of Public Health Dentistry

before the

United States Senate
Special Committee on Aging

As a participant in the forum on

"Ageism in Health Care: Are our Nation's Seniors
Receiving Proper Oral Health Care?"

By:

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September 22, 2003

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Good Afternoon.

Mr. Chairman and members of the Senate Special Committee on Aging,

My name is Dr. Teresa Dolan, and I am dean of the University of Florida College of Dentistry. I am a board certified dental public health specialist with fellowship training in geriatric dentistry, and I am here today representing the American Association of Public Health Dentistry (AAPHD). AAPHD was formed in 1937 to improve the oral health of the public through education and leadership based on the principles of dental public health. AAPHD has over 800 members serving the public at the federal, state and local levels; as faculty and researchers in dental schools and schools of public health; and as consultants to industry and government. More than 500 of our members are dentists and many members hold a masters degree in public health.

Thank you for the opportunity to participate in this forum to discuss the state of oral health care being provided to our nation's seniors. I was asked to comment on the greatest oral health problems facing America's seniors.

Question 1. What are the greatest problems that America's seniors face where oral health is concerned?
The landmark Report of the Surgeon General on "Oral Health in America" clearly describes the diseases that affect senior Americans, including tooth decay, periodontal or gum disease, tooth loss and edentulism (the complete loss of teeth), and oral and pharyngeal cancers. For example, about one-third of all older Americans have no teeth. Others with few teeth or broken down teeth are disadvantaged in their food choices and their ability to communicate and meet social responsibilities within their families and communities.

Each year about 7,800 Americans die from cancers in the oral cavity and pharynx (throat), and most of these patients are over the age of 50 years. In addition, older adults experience chronic and disabling conditions such as oral-facial pain, temporomandibular disorders, Sjogren's Syndrome and other autoimmune disorders, and oral complications of systemic diseases such as diabetes.

While there have been gains in oral health status for the population as a whole, these gains have not been evenly distributed across subgroups of Americans. This is especially true for older adults, and particularly those who are poor, who are from racial and ethnic minority groups, and individuals with chronic disabling conditions and those residing in long term care facilities. These are the individuals who are least likely to visit their dentist and they experience significant barriers, often insurmountable, to receiving necessary dental care.

Why do these problems exist?
Today's seniors did not benefit from fluoridated water and other preventive and therapeutic advances that today's children experience. Thus, many seniors have accumulated multiple dental diseases and conditions over their lifetimes. In addition, older adults are more likely to experience chronic health conditions such as heart disease, cancer, stroke, diabetes and arthritis. As seniors become disabled due to these conditions, they are less able to perform daily oral care, and are less able to get to the dentist for physical, financial or other reasons.

Is Ageism involved?
Ageism, or stereotypes about old age, can affect the dental care of seniors from several perspectives - on the part of the individual, their family members and their health care providers. The older adult may assume that dental problems are a normal part of aging and their teeth are not worth treating and saving. When a senior becomes frail and unable to care for himself, family members and caregivers often are poorly prepared or fail to recognize the importance of daily mouth care and regular dental visits - resulting in new dental problems or the exacerbation of existing problems. Finally, health care practitioners may have similar misconceptions about oral health and aging. Thus, improved education and health awareness of all parties are important in addressing the potential impact of ageism on dental care and oral health.

What role does neglect play?
Most dental diseases are slowly progressing and chronic in nature. Dental neglect on the part of an individual or a caregiver, particularly in a nursing home or long term care facility, can result in devastating dental problems. For example, I was recently asked to review the case of a 96-year-old woman who expired after living in a nursing home for about two years. Until her placement in the nursing home, she visited her dentist twice a year and maintained almost a full set of healthy natural teeth. At the time of her death, almost every tooth in her mouth was diseased due to neglect. Why did this happen? Most likely, the patient was not able to care for herself. Her family was not aware of the need to clean her mouth or assumed the nursing staff would do so. The nursing home staff did not provide the necessary daily mouth care, and it was probably difficult for the nursing home to locate a dentist who was trained in geriatric dentistry and was comfortable providing care in the nursing home environment. In this case, financing the care was not an issue—the patient was relatively wealthy and could afford dental treatment. However, all across America patients like this do not receive necessary care as they become disabled or placed in nursing facilities. Likewise, older patients cared for at home often do not receive the care needed to maintain a healthy mouth, and even the most well intended caregiver has difficulty accessing dental services for their loved one.

To what extent is oral health covered by insurance versus out of pocket expenses for the elderly?
Because private dental insurance is typically an employment-related benefit, some individuals lose their dental coverage when they retire. As a consequence, people ages 65 years and older reported the lowest levels of coverage.

Eligibility for Medicaid does not ensure enrollment, and enrollment does not ensure that individuals obtain needed care. Barriers include patient and caregiver understanding of the value and importance of oral health, low reimbursement rates, and administrative burdens for both patient and provider. Disabled seniors and those residing in nursing facilities experience additional barriers to care due to the limited number of dental professionals trained in mobile dentistry and the use of portable dental equipment.

Dental services covered under Medicare are limited, and Medicare was not designed to insure routine dental care. The narrow definition of "medically necessary dental care" currently limits oral health services for many insured persons, particularly the elderly. Many state Medicaid programs do not cover adult dental services, and focus their programs on children.

Question 4. Describe any solutions and/or recommendations you may have for the Committee in the area of oral health care for our nation's seniors.
The following recommendations for improving the oral health care for seniors are drawn from the Report of the Surgeon General. Oral health must be acknowledged as an integral part of general health in the minds and actions of older Americans, their caregivers, health professionals, and policy makers. Through educational and advocacy efforts, we must change public perceptions and help people understand that oral diseases are not a normal part of aging.

Individuals of all ages can and should play a key role in practicing good health behaviors, and in doing so, can avoid some of the common oral diseases and conditions. Expanded health education and health promotion programs should include oral health topics to enhance the public's understanding of the meaning of oral health, effective preventive practices, and the relationship of the mouth to the rest of the body.

Educational efforts are needed to enhance the understanding of geriatric dental issues among other professionals, including dentists, dental hygienists, physicians, nurse practitioners, nurses, nurse aids and nursing home administrators. Dental education leaders should advocate for expansion of geriatric dentistry curriculum in dental and dental hygiene education. Federal support for training opportunities in geriatric dentistry have decreased over the

years, and this support is essential to create a leadership cadre within academic dentistry.

Policy leaders like you must advocate for the expanded capacity of the public health infrastructure throughout the nation to improve the safety net for our most vulnerable older adults. The public health capacity for addressing oral health is diluted and not integrated within public health programs. A national public health plan for oral health does not exist in general, and does not exist for older adults. Local, state and federal resources are limited in the personnel, equipment and facilities available to support oral health programs, and this is especially true for frail and disabled seniors.

The lack of dental insurance, private or public, is one of several impediments to obtaining oral health care. This is especially true for seniors who lose their insurance upon retirement, or who become disabled and unable to seek care. Individuals whose health is physically, mentally, and emotionally compromised need comprehensive integrated care – including oral health care. This is currently not available to most seniors.

From a policy perspective, it would be particularly helpful to expand and facilitate the implementation and financing of a broader definition of "medically necessary dental services." Likewise, Medicaid should be expanded to include broad coverage of basic dental services for poor older adults.

Additional research is needed to better understand the etiology and distribution of diseases in older adults, and the most cost effective ways to prevent and treat these conditions.

Conclusion and Summary

Mr. Chairman, thank you again for the opportunity to address these concerns. I briefly described the common oral diseases and conditions facing older adults, and the many factors associated with the inadequate access to dental care for many elders. The education of patients and caregivers as well as improved public and private financing of care is key to overcoming barriers to dental care and improving the oral health status of older Americans.

Thank you for your leadership on this important issue.

References

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 Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

Isman R, Isman B. *Oral Health in America White Paper: Access to Oral Health Services in the United States 1997 and Beyond.* Chicago: Oral Health America, 1997.

U.S. Department of Health and Human Services. A National Agenda for Geriatric Education: White Papers. Klein SM, ed. Rockville, MD: U.S. Department of Health and Human Services, Bureau of Health Professions, 1995.

STATEMENT OF THE

AMERICAN DENTAL ASSOCIATION

TO THE

UNITED STATES SENATE

SPECIAL COMMITTEE ON AGING

ON

AGEISM IN HEALTH CARE: ARE OUR NATION'S SENIORS RECEIVING PROPER ORAL HEALTH CARE?

SUBMITTED BY

JAMES A. HARRELL, D.D.S.

SEPTEMBER 22, 2003

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The American Dental Association (ADA) would like to thank Senators Larry Craig and John Breaux and the other members of the Senate Special Committee on Aging for holding a forum to address "Ageism in Health Care: Are Our Nation's Seniors Receiving Proper Oral Health Care." The ADA represents 147,000 licensed dentists (more than 70 percent of the profession) in the United States. The Association is thankful for the past interest and support the Committee has given to ensuring America's seniors have adequate access to oral health care. We appreciate the opportunity to appear today.

In 2001, the Surgeon General published the landmark report *Oral Health in America*, the first such document to focus exclusively on the nation's oral health and dental needs. The report identified troubling disparities in the nation's oral health, most pointedly among the elderly and children.

The ADA is concerned with ensuring that the regulatory and financial resources are in place to address the oral health care needs of the frail elderly, particularly those who reside in long-term care facilities. To do this effectively, it is important that oral health be recognized by dentists and non-dentists alike as an important component of overall health and well-being. Scientific research is currently underway to understand the associations observed between oral health and such serious systemic conditions as diabetes, cardiovascular disease, stroke and respiratory infections. Ensuring access to oral health care services results in a savings in overall health care expenditures and improvement in seniors' quality of life.

Oral health problems faced by seniors

It is important for the Committee, when we are talking about the oral health needs of seniors, to differentiate among seniors. Not all seniors lack access to oral health care, and, as a result, not all seniors have poor oral health. There is no `one size fits all' answer to addressing the question "What are the greatest oral health problems that America's seniors face?"

Scientific data show that Americans are living longer than ever before and are more likely to keep their natural teeth. Dentistry is proud of this achievement, which is a direct result of prevention and early intervention – hallmarks of dental practice. For those elderly who have limited economic means and for those weakened by serious, chronic disease, however, the ADA believes that improved access to dental care is needed. The Surgeon General's report stated that 23 percent of those aged 65 to 74 have severe gum disease, and oral and pharyngeal cancers are diagnosed in about 30,000 Americans annually – the highest prevalence of that disease is among the elderly. The frail elderly also suffer devastating oral health side effects from the use of multiple medications and treatments they receive for other diseases, particularly immuno-suppressant and radiation treatments.

Oral disease can also have a social impact on the elderly, affecting life functions (e.g., eating and digestion) and impacting quality of life. Problems with oral health care result

in pain and suffering; difficulty chewing and swallowing; and loss of self-esteem. For all of these reasons, access to oral health assessment and treatment is so critical.

According to the Surgeon General's report, "nursing homes and other long-term care institutions have limited capacity to deliver needed oral health services to their residents, most of whom are at increased risk for oral diseases." More must be done to improve the system for oral and dental care, considering that the low-income and frail elderly residents with special needs have complex physical and medical conditions and more serious and complicated dental disease. Congress has taken some important steps toward ensuring that quality of life is protected for those people residing in long-term care facilities. As a result of the Omnibus Budget and Reconciliation Act (OBRA) of 1987 and subsequent legislation, nursing facilities certified under Medicare or Medicaid or both are required to assess and provide for the oral/dental care of their residents as part of their general care. All nursing facilities must conduct a standardized, comprehensive assessment of each resident's health status, including their oral/dental condition. While statute and regulations provide the opportunity for dentistry to work with nursing facilities to best serve the long-term care population, there are holes in the system. Oversight of oral health has lagged behind other facility improvements that have been made over the years.

Responsibilities of stakeholders

The ADA in partnership with Special Care Dentistry and other stakeholders has been working with the Centers for Medicare and Medicaid Services (CMS) to address the specific problems that exist with the tools used by nursing facilities and state surveyors to assess a resident's oral health. Our collective goal is to improve the oral health assessment process in nursing facilities, and therefore, strengthen the enforcement of existing federal regulations. Better dental oversight will lead to better dental care and quality of life for nursing facility residents.

Affecting change in the current system in any form will require training of nursing facility staffs, state and federal surveyors, as well as the dental profession. In September 2001, CMS, for the first time, held a live web-cast training program for state surveyors to promote oral health screening and awareness. The ADA applauded this effort, which involved the nursing home facilities, nurses, physicians and many others. This was a terrific first step toward building awareness and elevating the importance of oral health for long-term care residents.

States have also pursued their own training programs to assist nursing facility staff. In Illinois, for example, dentists and dental hygienists are working together with the support of a grant from the Illinois Department of Public Health's Bureau of Long Term Care. Under this grant, the dental team has developed and is providing oral health care in-service training programs for nursing facility staff on oral health assessment and daily oral hygiene. This is a model that other states could surely duplicate to enhance access to care for those elderly most in need. Perhaps similar programs could be used in other home care settings, outside of long-term care.

All health providers serve as stakeholders when it comes to ensuring that the frail elderly – those with diseases, disabilities and other special needs- have access to quality oral health services. The dental profession's partners in this effort span the health care professions, from medical colleagues, social service agencies, health care industry, long-term care providers, home health agencies, community health officials, private health insurers, Medicaid and many others.

Dentists throughout the U.S. have developed partnerships with many of these stakeholders, working with portable and mobile equipment to deliver care to elderly in need and finding other innovative approaches to bring care to those who can't make it to the dental office themselves. There are numerous models in existence, and dentists in partnership with other stakeholders can and should explore opportunities to make these services more readily available.

Geriatric dental training

The ADA asserts that the aging of the population, increases in the numbers of people with disabilities, and a rapidly changing racial and ethnic profile requires a dental workforce that is confident and competent to address both routine and uncommon oral problems. The dental profession as a whole must be equipped to manage the oral health effects of comorbidities and medications, interacting more often with other health care providers, social service agencies and the nursing home industry. One should not have to be labeled or identified as a "geriatric" dentist to have understanding and training in providing care to the elderly. In fact, many dentists provide care to members of a family of all ages, from the very young through those in their elder years where this expertise is needed.

The Commission on Dental Accreditation of the American Dental Association serves the public by establishing, maintaining and applying standards that ensure the quality and continuous improvement of dental, advanced dental, and allied dental education programs. Currently, the Commission accredits more than 1,330 educational programs. The standards provide for the preparation of dental graduates to meet the oral health needs of the public.

Graduates of dental schools accredited by the Commission must be competent in providing dental care, as defined by the school, for geriatric patients. A May 2003 study in the *Journal of Dental Education* reported that all dental schools teach some aspects of geriatric dentistry, including 98% with required didactic curricula and 67% with a clinical component. Although the teaching of didactic content in geriatric dentistry has increased markedly in the last two decades, clinical training has lagged behind and some dental graduates report feeling unprepared in this area.

More than 2,700 individuals graduate annually from accredited advanced education programs in general dentistry or one of the nine dental specialties. Accreditation standards for these educational programs require that residents receive training at a level

of skill and complexity beyond that accomplished in pre-doctoral training for a variety of patients, including patients with special needs. Advanced general dentistry programs in particular emphasize training in comprehensive, multidisciplinary oral health care and some of these programs offer the option of an additional year of study with emphasis on the geriatric patient.

Although a handful of fellowships or advanced education programs that specifically focus on geriatric dentistry are offered in the United States, historically they have suffered from lack of adequate funding and under-enrollment. The ADA sponsors continuing education programs each year at its national meeting on dental care for elderly patients and those with chronic illnesses. The ADA also encourages dental schools to provide similar continuing education courses for all practicing dentists as well as to carry out research programs on the specialized techniques or methods of delivery for dental services to this vulnerable population.

Recommendations to improve oral health for seniors

According to the Surgeon General's report, many elderly lose their dental insurance once they enter retirement, leaving them with no prepayment benefit for care. The ADA supports the development of medical savings accounts for retired seniors who wish to save for their dental care and have the means to do so.

The financial complexities of long-term care also impact the delivery of dental services. No solid financial infrastructure for low-income seniors exists, as many states do not cover adult dental care under Medicaid or coverage is minimal. The ADA supports comprehensive dental benefits for low-income elderly individuals, with adequate reimbursement provided for care. The dental profession continues to emphasize that oral health care leads to overall cost savings to the health care system because dentistry emphasizes prevention and early intervention when disease does occur. Low-income seniors unable to pay for oral health care services should not be denied such care for financial reasons.

The ADA also believes it is essential that the dental community, nursing home industry, CMS and others continue to build on the progress that has been made to improve the nursing home oral health assessment and state survey requirements. It is so critically important that nursing facility residents are properly assessed for oral disease and referred to a dentist for treatment when necessary. The Association thanks the Committee for its leadership in this area.

The ADA stands willing to work with Congress and other stakeholders to identify other ways to achieve necessary improvements in access to oral health care for older Americans, particularly the frail elderly.

Statement

Of

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and

President
American Dental Education Association

Before the

Senate Special Committee on Aging

Hearing on

"Ageism in Health Care:
Are Our Nation's Seniors Receiving Proper Oral Health Care"

September 22, 2003

Good afternoon, Mr. Chairman, and members of the Select Committee on Aging. My name is Dr. Paula Friedman. I am a Professor and the Associate Dean of Administration at the Boston University Goldman School of Dental Medicine. As President of the American Dental Education Association (ADEA), I am pleased to offer testimony today with regard to whether there are enough dentists being educated to treat the elderly and how access to dental care for our elderly population can be improved.

ADEA is the premier national organization that speaks for dental education. It is dedicated to serving the needs of all 56 U.S. dental schools, 727 U.S. dental residency programs, 266 dental hygiene programs, 259 dental assisting programs, and 25 dental laboratory technology programs, as well as the 11,332 full- and part-time dental school faculty, more than 5,266 dental residents and the nation's 37,775 dental and allied dental students. It is at dental education institutions that future practitioners and researchers gain their knowledge; the majority of dental research is conducted; and significant dental care is provided to many underserved low-income populations, including individuals covered by Medicaid and the State Children's Health Insurance Program (SCHIP).

Dental Education's Role

The dental education community acknowledges its rightful role in preparing tomorrow's workforce to fully meet the oral health care needs of an aging and special needs population through education, research and training programs. In a recently published report of the ADEA President's Commission[1] a number of recommendations were made that address meeting the needs of the elderly. The report's recommendations are in five broad areas: (1) monitoring the future oral health care workforce needs, (2) improving the effectiveness of the oral health care delivery system, (3) preparing students to provide oral health services to diverse populations, (4) increasing the diversity of the oral health workforce, and (5) improving the effectiveness of allied dental professionals in reaching the underserved. The report is appended to this statement.

Today, I want to highlight actions that ADEA and/or its members are taking to fulfill the recommendations of the report. First, we are advocating for adequate curriculum time devoted to theoretical and practical considerations in providing care to patients with complex needs and circumstance, including those with developmental and other disabilities, the very young and the aged, and individuals with complex psychological and social situations. Second, we are collaborating with the ADA Commission on Dental Accreditation to adopt or strengthen accreditation standards at all levels of dental education related to competency in treatment of people with special needs.

Third, U.S. dental schools are committed to providing ample opportunities for dental students, residents, and allied dental students to gain exposure necessary to learn about and treat a broad spectrum of elderly patients. They offer rotations in off-site clinics to deliver oral health care to underserved populations as a means to develop culturally competent oral heath providers. They demand that graduates possess competencies that enhance and promote the total health of patients through oral health management of children, adolescents, adults, the elderly, and medically compromised.

The Federal Government's Role

While recognizing its own responsibilities in preparing a dental workforce to care for special needs populations, the dental education community strongly believes that the federal government is a critical partner in this endeavor.

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[1] "Improving the Oral Health Status of All Americans: Roles and Responsibilities of Academic Dental Institutions," American Dental Education Association, March 2003.

Consequently, ADEA recommends that Congress:

1) Provide federal funding for general dentistry residency training programs;
2) Broaden grantee eligibility to include dental education institutions for Geriatric Training for Physicians, Dentists and Behavioral/Mental Health Professionals and Geriatric Academic Career Awards;
3) Authorize a new federal geriatric dentistry program;
4) Authorize a new federal loan repayment program at NIH for research on geriatric population; and
5) Authorize a new federal reimbursement program for dental education institutions providing oral health care to the elderly.

The Access Problem

Although dentistry has been successful in preventing oral diseases and in developing effective and relatively inexpensive treatment methods, too many elderly Americans, poor and low-income persons, and minorities have been left behind, resulting in needless pain, increased cost, and decreased health.

Some Facts about Older Adults

- 23% of 65 to 74-year-olds have severe periodontal disease;
- 30% of adults have no teeth (edentulous);
- Oral and pharyngeal cancers occur more often in adults with a lower 5-year survival rate lower in blacks (34%) than whites (56%);
- Prescriptions taken by older adults will have an oral side effect-usually dry mouth which increases the risk for oral disease;
- 5% of Americans aged 65 and older (1.65 million) are living in long-term care facilities where dental care is problematic; and
- Many elderly individuals lose their dental insurance when they retire. Medicaid reimbursement for adults in most states does not exist and Medicare is not designed to reimburse for routine dental care.

In all, an estimated 39.7 million Americans live in areas lacking adequate dental care services as defined by federal criteria under the Health Professional Shortage Area designation. More than 108 million people lack dental insurance, far outpacing the 44 million who lack health insurance. So it is no surprise that the aged, the poor, the rural and the disadvantaged have substantially less access to dental health care than they need or deserve.

Many of these people seek dental care only when the pain and infection creates a dental emergency. Often patients come to dental education institutions with severe problems, sometimes requiring hospitalization. Our institutions provide a dental "safety net" for elderly and other patients who do not have insurance coverage, public program coverage, or adequate resources to pay for dental care. Fees charged in a dental school clinic are around half that of the fees charged by private practitioners in the surrounding communities where they are located. In fact, dental schools and their satellite clinics provide millions of dollars of unreimbursed oral health care each year for elderly and other underserved populations.

According to a study conducted by the American Dental Association[2], slightly more than 18% of patients treated at dental school clinics are 65 years or older. Of all patients treated, 32% do not have an insurance program while half are covered by public assistance with a majority of patients having an income of $15,000 or less. Examples of the commitment dental education institutions are making to improve access for the elderly and others who are underserved can be found across the nation.

[2] "Study of Dental School Facilities and Programs," American Dental Association, August 1999.

For instance,

- In Louisiana, Louisiana State University School of Dentistry (LSUSD) sponsors and conducts numerous community dental education programs including annual oral cancer screenings in collaboration with the American Cancer Association and caregiver instruction to those who work in homes for the elderly. Oral health care is provided by dental students, residents and gratis faculty at the Veterans Administration Hospital.
- In Illinois, Southern Illinois University School of Dentistry (SIUSD) Metro East Dental Fund helps the underserved, including the elderly and children, to receive preventive and restorative dental services. The dental fund supports two major projects: "Restore-A-Smile" and "Kids Who Fall Between the Cracks." Began in 1997, Restore-A-Smile provides free dental services from to elderly, low-income patients identified by SIU School of Nursing. The East St. Louis Housing Authority provides transportation for the patients to the East St. Louis Clinic. A fair number of elderly patients have been fitted with dentures, which in a typical private practice would cost several thousand dollars. The quality of life for these elderly individuals has improved substantially in large part because of the free SIU dental care received.
- In Michigan the University of Michigan School of Dentistry (UMD), located in northwestern Detroit, has a strong urban mission. The School also has a 44-chair hospital based clinic located on the eastside of the city. The clinics provide care for geriatric, disabled, pediatric, HIV/AIDS and underserved populations. UDM is the major Medicaid dental care provider for residents in metropolitan Detroit. The School provides care in a number of outreach clinics. Students provide services in a clinic for the homeless and the working poor, and with portable dental equipment, to nursing home residents. There is a strong service-learning component to the dental hygiene and dental community dentistry courses that includes community education, screenings and other community based oral health projects.
- Wisconsin's only dental school, Marquette University School of Dentistry, annually serves an average of 15,000 patients providing over 69,000 patient visits. Approximately 35% of the patients served at the School's Main Clinic represent minorities, while 32% include low-income individuals with SCHIP or Medicaid status. The School of Dentistry is also the site of the Center for Orofacial Research and Education, as well as a crucial partner providing support for the Wisconsin Geriatric Education Center at Marquette.
- And, lastly, in my own Commonwealth of Massachusetts, Boston University's Goldman School of Dental Medicine offers programs for nursing home residents and homebound elders, homeless and battered women, immigrant populations, HIV/AIDS patients, and spinal cord injury patients with a total of 56,240 patient visits. The dental school is the largest Medicaid provider of oral health services in Massachusetts. In partnership with the Massachusetts Dental Society, the Goldman School of Dentistry provides oral health screenings annually for physically and mentally challenged athletes in the Special Olympics. In the area of dental research, the School's Center for Implantology conducts studies to improve oral health services for edentulous patients, while its Department of Health Policy and Health Services Research engages in research on aging, the interrelationship of oral disease and systemic disease, and expanding access to linguistically and culturally underserved populations.

The Cost of Access

No conversation with regard to access to oral health care would be complete without reviewing how dental care is reimbursed. It is paid for in a variety of ways based on a fee for service schedule:

1. If a patient is enrolled in Medicaid or S-CHIP, payment for dental care is paid directly to the provider through the Medicaid or S-CHIP program in the state. The patient does not have a co-payment if enrolled in the Medicaid program. Patients enrolled in S-CHIP may have a co-payment, which is dependent on their state plan;

2 Federally Qualified Health Clinics (FQHCs) require a co-payment from the patient based on a sliding fee schedule calculated by family income, and the remainder is paid to the dental provider through the FQHC program;
3 Dental insurance, regardless if provided through an employer or privately purchased, has varying degrees of coverage paid to the dental provider. Expenses not covered by insurance are paid by the patient (out of pocket cost); and
4 Patients without program support (federal or state) or without dental insurance coverage pay for services directly (out of pocket costs).

The Dental Workforce

Significant challenges aside from economic barriers posed by lack of dental insurance influence the oral health delivery system—the need to educate and train adequate numbers of dentists in the special oral health care needed for the elderly population and the need for our institutions to conduct research more that fully includes the elderly.

Approximately 4,350 dental students graduate annually from 56 U.S. dental schools located in 34 states, the District of Columbia and Puerto Rico. Despite this number, the dental workforce is not keeping pace with demand. Some states lacking a dental school are seeking solutions to their oral health care needs through partnerships with states that have schools, seeking to establish residency programs, and some have contemplated opening schools. The latest state to open a school, Nevada, welcomed its inaugural class in 2002.

The ratio of professionally active dentist-to-population is projected to continue declining, from its peak of 60:100,000 in 1994 to 54:100,000 in 2020[3]. As a sizable portion of the U.S. population has difficulty availing itself of needed or wanted oral health care, the decline is creating concern as to the capability of the dental workforce to meet emerging demands of society and provide services efficiently.

Based on the age distribution of the dental workforce, it can be estimated that approximately 50 percent of the current dental workforce will retire over the next 20 years. In the next ten years, between 22 to 25 percent of professionally active dentists will retire from the workforce; and by 2015, the number of dental graduates will not be large enough to replace the number of dentists leaving the workforce. Action needs to be taken now to address this looming problem, especially if the access needs for elderly and other underserved populations is to be successfully tackled.

Possessing good oral health is critical to the overall health of a person. Unfortunately, all too often when examining the issue of geriatric health, the dental workforce and oral health care for the elderly are "forgotten." Examples of this regrettable omission can be found in recent publications, "The State of Aging and Health in America," published by the Merck Institute of Aging & Health and The Gerontological Society of America and in "Emerging Crisis: The Geriatric Care Workforce," published in the Public Policy & Aging Report, Spring 2003, Vol. 13, Number 2. This publication contains articles on geriatric mental health workforce, nursing, social work, physicians, but no mention of dentistry or oral health is listed.

Clearly, we must redouble our collective efforts to raise the level of visibility of dentistry as a part of primary health care and the importance of oral health as part of overall health. We must continue to publicize the Surgeon General's Report[4] that alerts Congress and the nation to recognize the importance of oral health and the deleterious effects of inadequate oral health care. It calls attention to the fact that the burden of oral diseases is disproportionate among the U.S. population. Reports from the General Accounting Office and the National Governors Association corroborate these findings.

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[3] "Future of Dentistry," American Dental Association, Health Policy Resources Center, 2001.
[4] "U.S. Surgeon General Report: Oral Health in America", 2000.

Training programs play a significant role in responding positively to the challenges of oral health disparities for elderly Americans, dental education, and the workforce that are outlined in the Surgeon General's Report.[5] The federal government's commitment to continued funding and expansion of residency training, geriatric education and research programs, is a key that can help ameliorate problems faced by the elderly in accessing oral health care. Federal funding unlocks the doors of promise in America – the promise of access for underserved communities, the promise to students who seek to achieve their dream of becoming a dentist, and the promise that federal investments made in health education and research will be benefit all people in the United States.

Therefore, ADEA recommends that Congress redouble its efforts with regard to expanding and funding training programs that will assist in preparing the dental workforce to meet the needs of an aging population:

1. Fully fund the General Dentistry Residency Training

General dentistry residency programs provide dentists with enhanced skills and broad clinical experiences needed to deliver a broad array of oral health services to a wide spectrum of patients with complex medical needs, including elderly, special needs, medically compromised, as well as Medicaid and SCHIP populations. Dentists completing general dentistry training are better equipped to address a wide variety of oral health maladies without referring patients to specialists. The Institute of Medicine's (IOM) 1995 report[6] on dental education recommended the creation of additional General Dentistry Residency positions to accommodate all dental school graduates. Approximately 1,951 residents train annually in the country's 311 accredited general dentistry programs. Funding for this program must continue in FY 2004. At present this critically important program is been zero funded.

ADEA recommends that Congress provide funding to fulfill the IOM's recommendation.

2. Broaden Grantee Eligibility for Geriatric Training Programs

There are four federal grant programs are authorized and funded that support geriatric education and training: 1) Geriatric Education Centers (GEC); 2) Geriatric Training for Physicians, Dentists and Behavioral/Mental Health Professionals (GTPD); 3) Geriatric Academic Career Awards (GAC); and 4) Geriatric Nursing Knowledge and Experiences in Long Term Care Facilities.

Dental education institutions may only compete for GECs. These programs aim to improve the training of health professionals in geriatrics and develop and disseminate curricula relating to the treatment of the health problems of elderly individuals. Grant funding may be used to support the training and retraining of faculty to provide instruction in geriatrics and continuing education of health professionals who provide geriatric care. Students received clinical training in geriatrics in nursing homes, chronic and acute disease hospitals, ambulatory care centers, and senior centers. In 2003, it is expected that only limited funding of $2 million will be available for up to five grantees.

The GTPD provides training in geriatrics through two-year fellowship programs and/or 1-year retraining programs that include clinical, research, administration, and teaching. A minimum of three fellows – one from each discipline of medicine, dentistry and mental health – is required

[5] "U.S. Surgeon General Report: Oral Health in America", 2000.
[6] "Dental Education at the Crossroads: Challenges and Change", 1995.

each year of the award. Only schools of medicine may apply for GTPD grants. Limited funding of approximately $2 million is expected in 2003 for up to five grantees.

ADEA recommends that dental education institutions be allowed to complete for grants under the GTPD program.

GAC awards support career development of geriatricians in junior faculty positions who teach clinical geriatrics. Recipients are required to provide training in clinical geriatrics. Eligible applicants must be board certified or board eligible in internal medicine, family practice or psychiatry, have completed an approved fellowship program in geriatrics and hold a junior faculty appointment at an accredited school of medicine.

ADEA recommends that criteria be broadened so that faculty members employed by U.S. dental schools are eligible to compete for GAC awards.

3. Authorize a New Geriatric Dentistry Residency Training Programs

Although dental needs of the elderly are changing and growing, geriatric dentistry is not a recognized specialty by the Commission on Dental Accreditation. However, there are a small number of geriatric residency programs provide specialized training to residents each year across the country. These programs recognize that the management of older patients requires not only an understanding of the medical and dental aspects of aging, but also of many other factors such as ambulation, independent living, socialization, and sensory function.

Many barriers interfere with providing elderly with dental care, including dental complexity, multiple medical conditions, diminished functional status, loss of independence and limited finances. The new federally funded residency training program in geriatric dentistry would provide both a clinical and research focus preparing graduates for all aspects of clinical care for elderly patients and prepare graduates to pursue careers as academicians. The core curriculum would focus on expanding the resident's knowledge of the aging process, epidemiology, biostatistics, research methodology, health care delivery systems, psychosocial aspects of aging, geriatric medicine for dentists, geropharmacy, geriatric nutrition and teaching strategies. In addition the program would provide research experience to gain skills in the design, implementation, analysis, and reporting of findings from their chosen research project under faculty supervision.

ADEA recommends that a new federal grant program modeled on the general and pediatric dentistry residency programs be authorized by Congress to prepare the dental workforce to meet the growing needs of an aging population.

4. Authorize a new NIH loan repayment program for research on the elderly and other special needs populations

Research is the connection between oral health and general health is widely acknowledged. A thorough oral examination can detect signs of nutritional deficiencies as well as a number of systemic diseases, including microbial infections, immune disorders, injuries, and some cancers. According to the Surgeon General's Report on Oral Health, more than 90 percent of all systemic diseases have oral manifestations. Cancer, for instance, can first appear on the tongue or soft palate. The mouth can provide some of the earliest indications of diabetes and HIV/AIDS. Radiographic or magnetic resonance imaging of oral bone can help identify the onset of osteoporosis.

By learning more about these associations, we can find better ways to pass this knowledge along to patients, all patients including the elderly. To assure continued dental health research is a growing body of knowledge that can be applied to patients more researchers are needed.

The Surgeon General reported that dental schools throughout the nation are struggling to recruit and retain top faculty who conduct such research. This is a crisis that threatens the quality of dental education, oral, dental, and craniofacial research, and, ultimately, access to necessary oral health care for Americans. Presently, there are approximately 350 vacant faculty positions at the 56 U.S. dental schools. The issue of access to care cannot be addressed successfully without increasing the numbers of dentists entering academia and research.

Every American should appreciate the advances in dental health research. As the Surgeon General's report notes, the past half-century has seen the meaning of dental health evolve from a concern over just teeth and gums to a much broader systemic focus. Now we must capitalize on this new knowledge – and make sure this research reaches all Americans including the elderly.

The National Institutes of Health has five authorized and funded loan repayment programs that can repay up to $35,000 a year of qualified educational debt for health professionals pursuing careers in clinical, pediatric, contraception and infertility, or health disparities research. None of these programs focus on the elderly.

ADEA recommends that Congress authorize a new NIH loan repayment program for research on the elderly and other special needs populations.

5. Authorize a new Reimbursement Program for Elderly Dental Care at Academic Dental Institutions

Oral health care is not a benefit covered under Medicare, which exacerbates access by elderly to needed care. Despite the fact that dental schools and their satellite clinics provide a significant amount of oral health care to the elderly more needs to be done. Dental schools cannot expand services beyond what is being done if federal assistance is not made available to assist in paying for unreimbursed care.

ADEA urges Congress to authorize a dental reimbursement program for poor elderly obtaining treatment at the nation's dental education institutions.

Such a program would not only help to increase access to oral health care by the poor elderly but would also enhance training and education opportunities for both predoctoral and residents in geriatric oral health care.

The new program could be modeled on the modestly funded dental reimbursement program authorized under the Ryan White CARE Act that helps to train students and residents in caring for HIV/AIDS patients' oral health care needs. This program is a successful cost-effective federal-institutional partnership that provides quality oral health care to people living with HIV/AIDS while training providers to effectively and safely deliver care to these patients. Dental education institutions apply for partial reimbursement for the costs of providing oral health care services to people living with HIV and AIDS.

Conclusion

In conclusion, I turn your attention to recommendations made in a 1995 U.S. Department of Health and Human Services report entitled, "A National Agenda for Geriatric Education." The White Paper contains a chapter, "The State of the Art of Geriatric Dental Education and Training," that includes a number of recommendations including: 1) increase the number of general dentistry training programs, 2) increase the number of academic training opportunities for dental faculty, 3) increase the number of general dentistry training programs offering advanced geriatric dental training; and 4) increase funding for geriatric research and research training. I have appended to my written statement the report's recommendations for dentistry.

Mr. Chairman, on behalf of the American Dental Education Association, I thank you and the Committee for the opportunity to make recommendations on how Congress, dental education and the country can help to address the growing needs of the elderly population in gaining access to oral health care and increasing the numbers of well-trained dentists in meeting these needs.

RECOMMENDATIONS FROM A NATIONAL AGENDA FOR GERIATRIC EDUCATION: WHITE PAPERS

Edited by Susan M. Klein, DNSc, RN
U.S. Department of Health & Human Services, Public Health Service
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1995

The following recommendations are excerpts from A National Agenda for Geriatric Education: White Papers, Volume 1, Administrative Document. What follows is the complete text of each recommendation, including the rationale, and action(s) required.

DENTISTRY

RECOMMENDATIONS

Oral Health, Primary Care, and Reimbursement

1. Recognize oral health care as an integral part of primary care.

Rationale: The vast majority of dentists are general practitioners. Frequently they are the first contact health care professionals providing primary oral health care services to older patients. These dentists provide a comprehensive range of diagnostic, therapeutic, preventive, and rehabilitative treatments. Furthermore, this first contact care is coordinated, longitudinal, comprehensive and preventive -the elements of primary care. These older patients often require medical, social, and/or legal services in addition to oral health care. Therefore, oral health care also functions as a gateway into the larger system of health, social, and legal support services through the recognition of these needs by the dentist and referral to the appropriate individual or agency.

Action Required: Recognize dentists as primary care providers in health care literature, public policy pronouncements, legislative mandates, and regulatory interpretations of legislation.

2. Establish dental coverage as an essential component of any comprehensive health benefits package and increase access programs for special needs patients.

Rationale: Economically disadvantaged and physically impaired older adults are most likely to experience oral problems which can greatly influence their general health and quality of life. Cost significantly deters dental utilization by these "at-risk" older patients. Medicare dental reimbursement is extremely limited, and most states have no adult Medicaid dental coverage or use reimbursement schedules below 50% of prevailing fees. Only 10% of older adults have private dental insurance and nearly 80% of annual dental expenditures are out-of-pocket expenses. These unfavorable economic realities have discouraged the development or expansion of geriatric dental clinical programs by dental schools. A limited number of programs sponsored by organized dentistry, dental schools, and other organizations have attempted to improve dental access for at risk older adults, but typically demand far exceeds project capacities.

Actions Required
1) Establish Medicare dental benefits to include a full range of preventive and rehabilitative services and expand Medicaid oral health coverage for older adults with reimbursement rates comparable to prevailing fees;
2) Increase options for private dental insurance coverage for older adults;
3) Initiate and improve access programs for special needs patients.

3. Implement detailed workforce analyses to define present and future needs for trained geriatric dental personnel in academic and clinical settings.

Rationale: Current information necessary to accurately project dental workforce needs for the elderly is lacking. A carefully designed and regularly scheduled analysis evaluating older population characteristics, trends in prevalence and incidence of dental diseases, perceived need and demand for care, and standards of care issues is required. These findings will help in the implementation of new policies to ensure a sufficient number and distribution of qualified academic leaders and clinical dental providers (including the allied disciplines) in geriatric

dentistry. Workforce study findings will provide data useful for identifying and differentiating skills necessary for geriatric clinicians and academicians (in order to develop better training programs) and propose viable strategies for continued monitoring of geriatric dentistry workforce concerns.

Action Required: Conduct periodic, federally funded geriatric dental workforce studies.

4. Develop, implement, and evaluate geriatric dentistry clinical competencies and educational standards.

Rationale: There is little agreement on the specific clinical competencies and appropriate level of education and training necessary for all dental providers, including new dental graduates, advanced general dentistry students, general practitioners, dental specialists providing care to older patients, clinical faculty, geriatric academicians, and dental auxiliaries. The continuous improvement of quality in geriatric educational and training programs depends on more effective ways of evaluating and improving educational programs to achieve competencies.

Action Required: Convene a task force of dental educators and clinicians to determine educational standards/requirements and clinical competencies that are appropriate for geriatric dental practitioners, clinical faculty, and academicians; include representatives of the appropriate AADS sections; ASGD; the Academy of General Dentistry (AGD).

5. Dental school accreditation standards will require geriatrics education.

Rationale: Older patients represent a diverse group of people with a wide range of physical, medical and psychosocial presentations any or all of which may vary from appointment to appointment and will affect the type of dental care required. Older adults also have different patterns and prevalence of oral diseases and are seeking dental care in greater numbers than in the past. Homebound adults and institutionalized elders may require on-site or bedside dental care. Educational offerings to prepare students to meet the oral health needs of independent, frail, and functionally dependent elders and to determine the appropriate treatment and setting for care delivery will allow practitioners to provide appropriate quality care for older adults. These geriatric issues are a necessary component of the curriculum for all predoctoral, appropriate postdoctoral training programs, and allied dental health programs.

Actions Required
1) Incorporate geriatric dentistry curriculum as a required part of all dental predoctoral, appropriate postdoctoral training programs {advanced education in general dentistry programs (AEGDs), general practice residency programs (GPRs) and dental specialties which treat older patients}, and allied dental programs;
2) Develop, implement, and evaluate mandatory standards for geriatric components by accreditation boards in consultation with gerontological and geriatric dental experts.

6. Establish geriatric dentistry core content in national dental and dental hygiene boards and regional/state licensure board examinations.

Rationale: A growing number of elderly will be utilizing dental services during the next 20 years and nearly 40 % of these older adults will present with complex health and functional problems. To ensure adequately trained dental providers, a sufficient number of representative geriatric dental. Topics must be included within the staged testing required for graduation and licensure.

Actions Required
1) Identify key geriatric dentistry knowledge and clinical competency skills;
2) Increase national board geriatrics content;
3) Expand testing of geriatrics content in regional/state licensure examinations.

7. Educate all health professional students in the principles of inter- disciplinary team management to include the oral needs of older patients.

Rationale: Dental education historically has included preventive, diagnostic, therapeutic and rehabilitative topics in its curriculum. It should continue to do so, emphasizing and expanding those topics to cover the findings and treatment needs of older patients. In addition, the appropriateness of case consultations and referrals to both

dental specialists and other health care professionals who can satisfy a wide variety of health and social services needs of the elderly should also be stressed.

Interdisciplinary team training curriculum includes information about communication skills, conflict management, and the roles of all disciplines represented on the team. This enables dental team members to appreciate the contributions of other health disciplines and fosters communication among them. Other health professionals need to understand the breadth and scope of the abilities of dentists and allied dental health personnel to manage the oral health needs of medically compromised older patients. This is particularly true since the prognosis of frail older patients managed by an interdisciplinary team is better than the prognosis of patients not managed this way.

Actions Required
1) Include the principles of interdisciplinary team training as a required element in dental and allied dental curricula; provide learning opportunities for these students to function as participating members of an interdisciplinary health care team in clinical settings;
2) Incorporate interdisciplinary team training into standards for dental school accreditation;
3) Include education on the oral health needs of older adults, and the contributions of dental health personnel to their interdisciplinary management in the curricula of health professions schools.

8. Employ continuous quality improvement (CQI) to improve dental education and the dental care of older patients.

Rationale: The principles and process of CQI has been shown to improve the quality of educational programs as well as patient care. Few dental health faculty and practitioners have the knowledge and skills to assess the structure, process, and outcomes of dental education and/or service programs in which they work to improve the quality of services provided. Faculty must learn the most effective methods of educating adult trainees and determine outcomes in the form of competencies. Dental providers must learn the most effective treatments for geriatric dental care and the expected patient outcomes. Improvements can be accomplished through activities such as problem solving, goal setting and achievement, and continuing education (CE) coursework.

Actions Required
1) Employ CQI to evaluate clinical and didactic educational outcomes;
2) Include the principles and procedures of CQI in all dental and allied dental curricula, providing opportunities to participate in CQI activities in a dental treatment program;
3) Incorporate CQI training into the standards for school accreditation.

Geriatric Dentistry Postdoctoral

9. Increase the number of postdoctoral general dentistry training programs

Rationale: The rapidly growing biomedical knowledge base and technological breakthroughs are challenging dental schools to produce dentists with up-to- date skills needed to successfully treat older adults. Due to this challenge and on-going demand (nearly 40% of graduating dental students applied to GPR/ AEGD programs but positions were not available for over 20% of them), the ADA's Council on Dental Education recently endorsed the creation of additional positions in postgraduate programs in general dentistry. GPR and AEGD programs facilitate the difficult transition from dental school into general practice through advanced didactic training and clinical experience. Opportunities for training these students to successfully treat the frail and functionally compromised elderly are quite promising, especially within a 2-year program format.

Action Required: Fund additional postdoctoral general education programs.

10. Increase the number of postdoctoral academic training opportunities for dental faculty.

Rationale: The 1987 DHHS Report to Congress, Personnel for Health Needs of the Elderly Through Year 2020, emphasized the enhanced training of dental providers as an important priority, and concluded that existing programs would not generate the required number of trained geriatric dentists. Currently, there are very limited postdoctoral educational opportunities available in geriatric dentistry. In addition to the few university-based masters level educational programs, there are 9 faculty training projects (FTPs) funded by the BHPr, which are

the only FTPs in geriatric dentistry currently available in the U.S. Additional positions are needed to retrain dental faculty in the clinical, teaching, and research skills to be successful academicians and leaders in the field. Other innovative strategies such as preceptorships and release time to develop research skills are needed for faculty interested in aging and oral health.

Action Required: Establish additional 2-year fellowship training programs, 1-year retraining programs, and other innovative models to train academic leaders in geriatric dentistry.

11. Postdoctoral general dentistry training programs must offer advanced geriatric dental training.

Rationale: Advanced general dentistry skills are needed to provide effective oral health care to many older adults. Dentists are treating larger numbers of older adults with challenging physical and psychosocial impairments which can negatively alter the outcome of dental care. Additionally, the oral heath problems of the elderly can be remarkably complex. Postdoctoral opportunities to treat a wide range of "at risk" older patients vary considerably across programs. In order to qualify dentists to meet the challenges of dental care provision to elders, all GPR/ AEGD programs must provide meaningful community and/or hospital-based geriatric dentistry training opportunities for residents. Efforts need to focus on building and refining advanced curricular and clinical content to establish the competence and confidence of general dentists.

Actions Required
1) Establish didactic and clinical experiences treating the functionally dependent and frail older dental patients in all GPR/AEGD programs;
2) Evaluate effectiveness in teaching geriatric dentistry through the GPR/ AEGD accreditation process.

12. Increase the number and types of alternate pathways to geriatric education available for dental professionals to encourage life-long learning.

Rationale: Education and training in geriatric dentistry available to dental professionals is limited to traditional CE programs which are generally poorly attended, or too superficial to meet practitioner needs. Alternative pathways to geriatric education for practicing dental personnel must be explored and developed. Because CE attendees are adult clinicians, androgogical techniques should be employed, and must include hands-on clinical experiences.

Actions Required: Increase the number of:
1) GECs with dental training programs;
2) CE programs with hands-on clinical care in a variety of extended care settings and other non-traditional educational opportunities;
3) CE programs conducted collaboratively by schools, VAs, dental organizations, GECs, and Area Health Education Centers (AHECs).

13. Increase funding for geriatric research and research training.

Rationale: The knowledge base in oral health and aging must continue to expand to serve as a foundation for education and training programs in geriatrics, and to guide practitioners as they provide cost effective care to older patients. This expansion will occur only with adequate research funding. Basic research is needed to understand the effects of the aging process on the oral cavity and its functions. Clinical research is needed to better understand the etiologies and treatments of oral diseases and their relationship to systemic disorders commonly affecting older adults. Health services research is needed to examine issues of access, appropriateness of care, and maximizing clinical outcomes for services provided to older patients. Educational research is needed to support the development, evaluation, and enhancement of teaching methodologies and innovative educational programs and technologies.

Successful geriatric academicians must possess a variety of skills and attributes which include proficiency in scientific inquiry and methods, and grant writing. Thus, research training is an essential component of postdoctoral geriatric education and training. Students and researchers must be attracted to the field of geriatric dentistry to serve as role models and educators.

Actions Required
1) Fund additional research and research training programs in oral health and aging;
2) Fund career development grant opportunities for dental faculty interested in aging.

Underserved Populations and Geriatrics Education/Training

14. Recruit and retain underrepresented ethnic/racial minority dental and allied dental health students and faculty in geriatrics and other fields of dentistry.

Rationale: Underrepresented ethnic/racial minorities in the dental profession include Blacks, Hispanics, and American Indians. In 1991, although minorities constituted 22% of the U.S. population, they accounted for only 13.5% of dental school enrollment. Many of these minority students are educated at the 2 schools of dentistry at the Historically Black Colleges and Universities. Similarly, there are very few clinical and academic minority faculty in geriatric dentistry and allied dental health to serve as role models for these students. While education and training opportunities in geriatric dentistry are minimal at best for all dental providers, even fewer training opportunities specific to minority oral health issues are offered in dentistry.

Actions Required
1) Expand geriatric dentistry educational and training opportunities at the faculty development and advanced general dental educational levels, and offer funding preferences for programs successful in the recruitment and retention of minority participants;
2) Expand current efforts to recruit and retain underrepresented minority students into dental and allied dental geriatric and other educational programs;
3) Expand the recruitment and retention of underrepresented minority faculty into academic leadership roles to serve as role models.

15. Include culturally relevant geriatric curricula in dental and allied dental programs.

Actions Required
1) Develop consensus documents outlining culturally relevant geriatric content for dental and allied dental curricula;
2) Develop ethnogeriatric materials for dental education;
3) Incorporate culturally relevant geriatric content in dental and allied dental curricula.

16. Recruit and retain dental providers for underserved older populations.

Rationale: Underserved older adult groups include those with special needs such as the homebound, long term care residents, ethnic/racial minority groups, rural or inner city residents, and/or those with limited ability to pay for dental services. Dental providers often find serving these groups unattractive due to financial considerations, practice preferences, or inadequate education and training to meet the special health care needs of some elders.. Educational debts averaging $60,000 makes it more difficult for dental graduates to practice in underserved areas.

Community-based settings for the underserved are often unfamiliar or considered unattractive to graduating students. Dental and allied dental health students have limited exposure to underserved populations and community-based faculty role models. Budget restrictions within dental and allied dental health programs have resulted in a decline in extramural clinical training experiences, as well as training in nontraditional delivery settings. The decreased funding for the BHPr FTPs and for GECs has also decreased training opportunities in geriatric dentistry.

Actions Required
1) Funding to develop, implement, and evaluate model community-based geriatric dental educational programs;
2) Continue the BHPr funding priority for FTP applicants "that demonstrate linkages for the purpose of training educators serving the minority and low income elderly";
3) Link state support for dental and allied dental education to clinical experiences in geriatric dentistry in community-based settings with appropriate faculty role models;
4) Expand loan repayment programs for dental graduates practicing in underserved areas.

17. Reduce regulatory practice barriers for qualified allied dental health professionals to provide selected dental health services in long term care settings.

Rationale: There is a severe shortage of dental practitioners serving individuals in long term care settings (e.g. private homes, nursing homes, adult congregate living facilities, congregate meal sites). In order to address the substantial unmet dental needs of older adults residing in these settings as well as provide high quality cost-effective care, dental teams including expanded function dental auxiliaries (dental hygienists and assistants) should be assembled. Current state dental practice acts generally do not allow: hygienists to provide dental treatment and education under general supervision; dental assistants to provide expanded rehabilitative dental functions; and/or dental laboratory technicians to assume more responsibilities in prosthodontic fabrications.

Actions Required
1) Develop guidelines associated with utilization of allied dental providers in long-term care settings;
2) Change state dental practice acts to allow expanded use of qualified allied dental personnel within alternative care settings.

Educational Technology

18. Develop, implement, and evaluate innovative educational strategies for teaching geriatrics using model educational technologies.

Rationale: Older patients seeking dental care vary greatly in terms of their physical abilities, medical conditions, mental status, and social milieu. This must be considered when individualizing dental treatment. Educational programs to foster the development of critical decision-making skills for managing the complicated diagnostic and treatment realities presented by older patients are vital. Geriatric dentistry is an evolving field with a growing but incomplete body of in-depth knowledge. Life-long learning attitudes and behaviors are needed to encourage students to continue their growth in this field once formal training has ceased. To develop quality geriatric dentistry educational programs, faculty training in innovative curricular development opportunities and technical resources must be made available. The development of new innovative educational approaches is a scholarly activity worthy of significant consideration by respective universities for faculty promotion.

Actions Required
1) Develop innovative educational teaching programs in geriatric dentistry that advance critical decision-making skills and life-long learning attitudes and behaviors;
2) Develop effective educator-training programs in innovative educational methods;
3) Provide resources to support the faculty development of new creative educational programs;
4) Develop a consensus document which fosters inventive curricular development as a scholarly activity worthy of significant consideration during evaluation for promotion and/or tenure by universities.

19. Develop a geriatric dentistry database to facilitate technology transfer, curriculum development, "and research discoveries.

Rationale: A specialized database in dentistry with a dedicated geriatric dentistry archival and retrieval system is needed to facilitate the rapid expansion of information discovery and knowledge dissemination. The existence of a database dedicated to geriatric dentistry would improve the immediacy of access to already developed materials, expedite information retrieval, promote collaborations of students, faculty, researchers, and practitioners in the development of new knowledge and aid in technology transfer of new information. Educational methodologies, curricula, clinical papers, consumer oriented materials, professional and lay-:-oriented educational software programs, expert directories, short reports concerning new developments, clinical tips, and other types of information which have not typically been included in previous global data banks could be stored in this system.

Action Required: Develop a database specific to geriatric dentistry with the capability of including a variety of material/sources, particularly data which do not now reside in a central database.

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on

"Ageism in Health Care: Are Our Nation's Seniors Receiving Proper Oral Health Care?"

Forum
of the
Senate Special Committee on Aging

Honorable Larry E. Craig, Chairman
Honorable John Breaux, Ranking Member

September 22, 2003

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Introduction

The American Dental Hygienists' Association (ADHA) appreciates this opportunity to participate in the Senate Special Committee on Aging's forum, entitled "Ageism in Health Care: Are Our Nation's Seniors Receiving Proper Oral Health Care?" As Daniel Perry, Executive Director of the Alliance for Aging Research, has testified before this Committee, "[a]geism is a deep and often unconscious prejudice against the old, an attitude that permeates American culture. It is a particularly apparent and especially damaging frame of mind that surfaces all too often in healthcare settings where older patients predominate."

ADHA applauds the Senate Special Committee on Aging for holding this important forum on the oral health of America's seniors. ADHA is hopeful that henceforth, whenever Senators think of seniors' general health, they will also think of oral health. As the May 2000 *Oral Health in America: A Report of the Surgeon General* has confirmed, oral health is a fundamental part of overall health and general well-being. Further, as our population ages, it is expected that baby boomers will retain more natural teeth than previous seniors. Clearly, the oral health needs of the elderly will only increase in the future.

Probably the primary problem faced by the nation's elderly with respect to their oral health is a lack of access to needed and wanted oral health services. This lack of access is attributable to a number of factors, including lack of awareness of the importance of oral health to overall health and general well-being, inability to travel to reach dental services, scarcity of available dental providers, and lack of ability to pay for dental services (either through dental insurance or out of pocket). ADHA looks forward to working, in a multi-disciplinary way, to address these issues and meet the oral health needs of our nation's seniors. Indeed, ADHA believes that the experience, education and expertise of dental hygienists are now dramatically underutilized and that increased utilization of dental hygienists is an important part of the solution to the crisis in oral health care affecting our nation's seniors.

ADHA is the largest national organization representing the professional interests of the more than 120,000 dental hygienists across the country. Dental hygienists are preventive oral health professionals who are licensed in each of the fifty states. Dental hygienists are oral health educators and clinicians who, in coordination with dentists, provide preventive, educational, and therapeutic services supporting total health for the control of oral diseases and the promotion of oral health.

U.S. Surgeon General's May 2000 Report on Oral Health in America Chronicles the Oral Health of Older Adults

The U.S. Surgeon General issued *Oral Health in America: A Report of the Surgeon General* in May 2000. This landmark report confirms what dental hygienists have long

known: that oral health is an integral part of total health and that good oral health can be achieved. The Surgeon General's Report on Oral Health challenges all of us -- in both the public and private sectors -- to address the compelling evidence that not all Americans have achieved the same level of oral health and well-being. The Report describes a "silent epidemic" of oral disease, which disproportionately affects our most vulnerable citizens -- poor children, the elderly, and many members of racial and ethnic minority groups.

Key findings enumerated in the Report include:

1. Oral diseases and disorders in and of themselves affect health and well-being throughout life.

2. Safe and effective measures exist to prevent the most common dental diseases -- dental caries (tooth decay) and periodontal (gum) diseases.

3. Lifestyle behaviors that affect general health such as tobacco use, excessive alcohol use, and poor dietary choices affect oral and craniofacial health as well.

4. There are profound and consequential oral health disparities within the U.S. population.

5. More information is needed to improve America's oral health and eliminate health disparities.

6. The mouth reflects general health and well-being.

7. Oral diseases and conditions are associated with other health problems.

8. Scientific research is key to further reduction in the burden of diseases and disorders that affect the face, mouth and teeth.

Importantly, the Surgeon General's Report on Oral Health specifically examined the oral health of older adults. Key findings are set forth below:

1. Twenty-three percent of 65-74 year olds have severe periodontal disease (measured as 6 millimeters of periodontal attachment loss). At all ages men are more likely than women to have more severe disease, and at all ages people at the lowest socioeconomic levels have more severe periodontal disease.

2. About 30 percent of adults 65 years and older are edentulous (without natural teeth), compared to 46 percent 20 years ago. These figures are higher for those living in poverty.

3. Oral and pharyngeal cancers are diagnosed in about 30,000 Americans annually; 8,000 die from these diseases each year. These cancers are primarily diagnosed in the elderly. Prognosis is poor. The 5-year survival rate for white patients is 56 percent; for blacks, it is only 34 percent.

4. Most older Americans take both prescription and over-the-counter drugs. In all probability, at least one of the medications used will have an oral side effect—usually dry mouth. The inhibition of salivary flow increases the risk for oral disease because saliva contains antimicrobial components as well as minerals that can help rebuild tooth enamel after attack by acid-producing, decay-causing bacteria. Individuals in long-term care facilities are prescribed an average of eight drugs.

5. At any given time, 5 percent of Americans aged 65 and older (currently some 1.65 million people) are living in a long-term care facility where dental care is problematic.

6. Many elderly individuals lose their dental insurance when they retire. The situation may be worse for older women, who generally have lower incomes and may never have had dental insurance. Medicaid funds dental care for the low-income and disabled elderly in some states, but reimbursements are low. Medicare is not designed to reimburse for routine dental care.

The Oral Health Needs of Seniors in Long-Term Care Facilities Are Not Being Met

While only approximately 5% (1.65 million) of Americans over the age of 65 reside in long term care facilities, these seniors are among those Americans with the most limited access to oral health services. Indeed, between 80% and 96% of Americans over 65 years of age in long term care facilities have unmet oral health needs. Studies of the nursing home population reveal that:

- up to 78% have untreated caries;
- more than 40% have periodontal disease;
- up to 75% of those over 65 have lost some or all of their teeth;
- more than 50% of those over 75 are without teeth (edentulous); and

- 80% of those who are edentulous have dentures, but 18% of those without teeth do not use their dentures.[1]

A 1995 survey of 16,000 nursing homes found that at least 60% of nursing homes offered no regular dental services on site; dental services were available only through emergency call or off-site. More than 10% of nursing homes offered no oral health care services whatsoever to their residents[2].

This scarcity of oral health services for our elderly means that our nation's seniors have significant unmet oral health needs. This is problematic for a number of reasons, including:

- Oral health problems can impede speaking, chewing and swallowing, adversely affecting interpersonal relations and proper nutrition. Seniors who can not interact socially become increasingly isolated, which can lead to depression. Seniors who have difficulty with chewing and swallowing find it difficult to maintain a proper diet and to take required medications.
- Research increasingly demonstrates a link between oral health and systemic health. The presence of periodontal disease has been linked to a number of systemic conditions, including coronary heart disease and stroke.
- The Centers for Disease Control (CDC) reports that the mouth can serve as an early warning system, alerting oral health providers of possible trouble in other parts of the body. For example, studies in post-menopausal women suggest that bone loss in the lower jaw may precede the skeletal bone loss seen in osteoporosis.
- Oral health care providers routinely examine patients for oral cancer. The incidence of oral cancer (which includes lip, oral cavity, and pharyngeal cancer) increases with age and is difficult to detect without an oral exam. Persons 65 years of age and older are seven times more likely to be diagnosed with oral cancer than those under age 65. Indeed, more older Americans died from oral cancer than from skin cancer in 1997. Oral cancers result in approximately 8,000 deaths per year, more than half of these deaths are among persons 65 years of age and older.
- Seniors who are edentulous (without natural teeth) and lack well-fitting dentures often suffer from poor self esteem and may have difficulty with such fundamental activities as speaking, chewing, and eating.

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[1] Schwartz, Murray, "Dentistry for the Long Term Care Patient," *Dentistry Today*, Volume 22(1):52-57, January 2003.

[2] Gift, H., Cherry-Peppers, G., Oldakowski, R. "Oral Health in U.S. Nursing Homes: 1995," *Special Care in Dentistry*, Volume 18: 226-233, 1998.

Increased Access to Preventive Oral Health Services is Key to Improving the Oral Health of our Nation's Seniors. Additional Entry Points into the Oral Health Care Delivery System are Sorely Needed

Unlike most medical conditions, the three most common oral diseases -- dental caries (tooth decay), gingivitis (gum disease) and periodontitis (advanced gum and bone disease) -- are proven to be preventable with the provision of regular oral health care. Despite this prevention capability, too many of our seniors suffer from preventable dental disease. Clearly, more must be done to increase seniors' access to oral health care services.

While the profession of dental hygiene was founded in 1923 as a school-based profession, today the provision of dental hygiene services is largely tied to the private dental office. Increased utilization of dental hygienists in assisted-living facilities, nursing homes, and other sites -- with appropriate referral mechanisms in place to dentists -- will improve access to needed preventive oral health services. This increased access to preventive oral health services will likely result in decreased oral health care costs per capita and, more important, improvements in oral and total health.

ADHA feels strongly that restrictive dental hygiene supervision laws constitute one of the most significant barriers to oral health care services. Indeed, ADHA is committed to lessening such barriers, which restrict the outreach abilities of dental hygienists and tie oral health care delivery to the fee-for-service private dental office, where only a fraction of the population is served.

Some states *are* pioneering less restrictive supervision and practice setting requirements. These innovations facilitate increased access to oral health services. Maine and New Hampshire, for example, have what is called public health supervision, which is less restrictive than general supervision. Oregon and California have expanded dental hygiene practice through the use of limited access permits and special license designations like the Registered Dental Hygienist in Alternative Practice (RDHAP).

Other states have unsupervised practice, which means that a dental hygienist can initiate treatment based on his or her assessment of patient needs without the specific authorization of a dentist, treat the patient without the presence of a dentist, and maintain a provider-patient relationship without the participation of the patient's dentist of record

Today, ten states recognize dental hygienists as Medicaid providers of oral health services and provide direct reimbursement for their services. These states are: California, Colorado, Connecticut, Maine, Minnesota, Missouri, Nevada, New Mexico, Oregon and Washington. Other states should adopt this approach, which appropriately recognizes the experience, education and expertise of dental hygienists and fosters increased access to much needed Medicaid oral health services.

Today, 25 states (AZ, CA, CO, CT, HI, ID, IL, KS, KY, ME, MD, MT, MN, NV, NH, NM, ND, OK, OR, PA, SC, TX, UT, WA, and WI) allow dental hygienists to work in nursing homes. Further, 12 states (AZ, CA, CO, FL, KS, MN, NM, NV, OK, OR, TX, and WI) allow dental hygienists to visit homebound patients. ADHA encourages policymakers to recognize and encourage these innovations, which improve access to oral health care services and work to reduce the tremendous disparities in oral health in America.

Voices within the dental community also urge better utilization of dental hygienists .The March 2003 report "Improving the Oral Health Status of All Americans: Roles and Responsibilities of Academic Dental Institutions put forth by the American Dental Education Association President's Commission called for improving the effectiveness of allied dental professionals, such as dental hygienists, in reaching underserved Americans.

Workforce experts have recognized that dental hygienists can and must play an increasing role if the nation's oral health care needs are to be met. Indeed, a recent article (attached) in *Health Affairs* explored the oral health workforce and found:

> "abundant evidence that a sizable segment of the population does not have access" to private [dental] care, while the dental safety net is "poorly defined and underdeveloped." Dentists' participation in Medicaid is not robust; community health centers and public health facilities have scant dental capabilities; and Medicare offers no dental coverage. "Radical steps" will be needed to correct "a growing disconnect between the dominant pattern of practice...and the oral health needs of the nation,"...including new practice settings for dental care, integration of oral and primary health care, and expanded scope of practice for hygienists and other allied professions.[3]

On November 20, 2002, the National Governors Association Center for Best Practices published an issue brief detailing "State Efforts to Improve Children's Oral Health." While the brief focuses on children's oral health, the recommendations work across the age spectrum. The NGA Center for Best Practices recommends: "Maximizing auxiliary personnel can increase access to preventive services.... In most states, the scope of practice for auxiliary personnel is quite restricted, even when the services necessary don't require a dentist. Some states are restructuring their Dental practice Acts to maximize the use of dental hygienists...." Two illustrative examples highlighted by the NGA are set forth below.

- **Maine** changed the rules governing the practice of hygienists to allow them to practice in public health settings such as school health centers, hospitals, and

[3] Mertz, E. and O'Neil, E., "The Growing Challenge of Providing Oral Health Care Services To All Americans," *Health Affairs*, Volume 21, Number 5 September/October 2002, p.65.

public clinics without a dentist on site – provided that the hygienists have an established relationship with a dentist. The state believes this strategy offers great promise for addressing dentist shortages.

- **Minnesota** passed legislation in 2001 to allow dental hygienists to perform certain primary care functions without dentist supervision, provided they are employed by one of the following entities: hospitals, nursing homes, group homes, home health agencies, state-operated facilities, federal, state or local public health facilities, or community or tribal clinics. In order to qualify, the hygienist must meet prescribed practice experience requirements and must engage in a collaborative agreement with a dentist who authorizes and accepts responsibility for these hygienist services.[4]

ADHA urges Members of Congress to work toward shaping a future in which oral health services will be readily available to seniors and other Americans who need them. Facilitating better utilization of dental hygienists is a vital part of this future.

Education, Experience and Licensure Qualifies Dental Hygienists to Play an Increasing Role in Meeting the Oral Health Needs of the Elderly

As prevention specialists, dental hygienists understand that recognizing the connection between oral health and total health can prevent disease, treat problems while they are still manageable and conserve critical health care dollars. Dental hygienists are committed to improving the nation's oral health, an integral part of total health. Indeed, an increasing number of Americans could enjoy good oral health because the principal oral maladies (caries, gingivitis and periodontitis) are fully preventable with the provision of regular preventive oral health services such as those provided by dental hygienists.

A registered dental hygienist has graduated from a minimum two-year college program that includes classroom studies and extensive supervised clinical experience. A dental hygienist also must pass a national written exam and a comprehensive state clinical exam to earn the RDH (registered dental hygienist) license. In addition, 48 states require continuing education for licensure renewal.

The Commission on Dental Accreditation of the American Dental Association sets forth accreditation standards for dental hygiene education programs. These standards require dental hygiene graduates to be competent in caring for seniors. Accreditation Standard 2-18 specifically requires that graduates of accredited dental hygiene education programs must be competent in providing dental hygiene care for the child, adolescent, adult, **geriatric** and medically compromised patient (emphasis added). Accreditation Standard 2-21 further requires that "graduates must be competent in

[4] National Governors Association Center for Best Practices, Issue Brief, "State Efforts to Improve Children's Oral Health," November 20, 2002, p.6.

interpersonal and communication skills to effectively interact with **diverse** population groups" (emphasis added).

Regrettably, the experience, education and expertise of dental hygienists are now dramatically underutilized. ADHA wants to be part of the solution to the current problems of oral health disparities and inadequate access to oral health services for many Americans, including many seniors particularly those who are low-income, lack oral health insurance and/or reside in long-term care facilities. ADHA believes that increased utilization of dental hygienists is an important part of the solution to the nation's oral health crisis.

Workforce Issues

As the General Accounting Office (GAO) confirmed in two separate reports to Congress, "dental disease is a chronic problem among many low-income and vulnerable populations." The GAO further found that the major factor contributing to the low use of dental services among low-income persons who have coverage for dental services is "finding dentists to treat them."

Increased utilization of dental hygienists in non-traditional settings such as long-term care facilities and medical clinics would promote increased use of dental services among the elderly. These dental hygienists can serve as a pipeline that can refer patients to dentists. Increased utilization of dental hygiene services is critical to addressing the nation's crisis in access to oral health care for vulnerable populations, such as our nation's elderly.

Since 1990, the number of dentists per 100,000 U.S. population has continued to decline. This decline is predicted to continue so that by the year 2020 the number of dentists per 100,000 U.S. population will fall to 52.7. By contrast, since 1990, the number of dental hygiene programs has increased by 27% and, from 1985-1995, the number of dental hygiene graduates increased by 20%, while the number of dentist graduates declined by 23%.

Some states have begun to examine dental workforce issues. The WWAMI Center for Health Workforce Studies at the University of Washington assessed the patterns and consequences of the distribution of the dental workforce in Washington state. This November 2000 study revealed that Washington state "does not have a dental workforce sufficient to meet Healthy People 2010 goals." The study found that "gaps in the state dental workforce will be difficult to fill with dentists because the nationwide per capita supply of dentists is decreasing; specialization is increasing, and programs to encourage dentists to practice in underserved areas are limited." The study recommended that "policymakers should consider expanding the role of hygienists...to deliver some oral health services in shortage areas." In Washington state, policymakers have enacted a school sealant program for underserved populations

where dental hygienists provide the services without any requirement for authorization from a dentist.

ADHA urges that the Committee work to facilitate increased utilization of the experience, education and expertise of dental hygienists.

Lack of Oral Health Insurance

The failure to integrate oral health effectively into overall health is seen in the distinction between oral health insurance and medical insurance. While 43 million Americans lack medical insurance, a whopping 108 million -- or 45% of all Americans -- lack oral health insurance coverage. Studies show that those without dental insurance are less likely to see an oral health care provider than those with insurance. Moreover, the uninsured tend to visit an oral health care provider only when they have a problem and are less likely to have a regular provider, to use preventive care or to have all their dental needs met. State Medicaid programs provide limited adult dental services and Medicare provides virtually no dental services. Indeed, Medicare does not cover any routine oral health services and allows only a narrow exception for coverage of certain dental services necessary to the provision of Medicare covered medical services such as extraction of teeth prior to radiation treatment of the jaw.

Even those who have dental insurance coverage, particularly Medicaid beneficiaries, are not assured of access to care. One way to promote this goal is to facilitate state recognition of dental hygienists as Medicaid providers of oral health services. Indeed, states are increasingly recognizing dental hygienists as Medicaid providers and providing direct reimbursement for their services.

ADHA urges this Committee and all Members of Congress to work to strengthen and enhance Medicaid and SCHIP dental benefits and to provide both medically necessary and routine oral health services under Medicare. ADHA looks forward to a future in which all Americans have dental health insurance coverage.

Supporting the Work of Entities Within the U.S. Department of Health and Human Services

The federal oral health infrastructure must be strengthened. Oral health must be fully integrated into overall health. ADHA urges this Committee to actively promote oral health programs within the Department of Health and Human Services (HHS). ADHA is very pleased with the appointment of Dr. A. Conan Davis as the Chief Dental Officer at the Centers for Medicare and Medicaid Services (CMS). ADHA is hopeful that this position is now a permanent one. In addition, ADHA urges that this Committee work to encourage each state to name a Dental Director.

ADHA further encourages this Committee to buttress the important oral health work of the Oral Health Division of the Centers for Disease Control and Prevention, the Maternal and Child Health Bureau and the Oral Health Initiative of the Health Resources and Services Administration (HRSA).

An increased federal focus on oral health will yield positive results for the nation. To illustrate, the work of the National Institute on Dental and Craniofacial Research (NIDCR) in dental research has not only resulted in better oral health for the nation, it has also helped curb increases in oral health care costs. Americans save nearly $4 billion annually in dental bills because of advances in dental research and an increased emphasis on preventive oral health care, such as the widespread use of fluoride.

Improving the Nation's "Oral Health IQ"

This U.S. Senate forum today is a critically important step forward in the effort to change perceptions regarding oral health and oral disease so that oral health becomes an accepted component of general health. Indeed, the perceptions of the public, policymakers and health providers must be changed in order to ensure acceptance of oral health as an integral component of general health. AHDA urges members of the Senate Special Committee on Aging to work to educate their colleagues in Congress with respect to the importance of oral health to total health and general well-being. This hearing is an important signal to the public that oral health is important. ADHA hopes that further signals will be forthcoming.

The national oral health consciousness will not change overnight, but working together we can heighten the nation's "oral health IQ." ADHA is already working hard to change perceptions so that oral health is rightly recognized as a vital component of overall health and general well being. For example, ADHA has launched a public relations campaign to highlight the link between oral health and overall health. Our slogan is "Want Some Lifesaving Advice? Ask Your Dental Hygienist."

This ADHA campaign builds on the Surgeon General's report, which notes that signs and symptoms of many potentially life-threatening diseases appear first in the mouth, precisely when they are most treatable. Dental hygienists routinely look for such signs and symptoms. For example, most dental hygienists conduct a screening for oral cancer at every visit and can advise patients of suspicious conditions.

Conclusion

In closing, the American Dental Hygienists' Association appreciates this opportunity to participate in the Senate Special Committee on Aging's Forum on "Ageism in Health Care: Are Our Nation's Seniors Receiving Proper Oral Health Care." ADHA looks forward to a future in which the education, experience and expertise of dental

hygienists are appropriately recognized and utilized; this will increase seniors' access to oral health services and work to ameliorate oral health disparities. ADHA is committed to working with lawmakers, educators, researchers, policymakers, the public and dental and non-dental groups to improve the nation's oral health which, as *Oral Health in America: A Report of the Surgeon General* so rightly recognizes, is a vital part of overall health and well-being.

Thank you for this opportunity to submit the views of the American Dental Hygienists' Association. Please do not hesitate to contact ADHA Washington Counsel, Karen Sealander of McDermott, Will & Emery (202/756-8024), with questions or for further information.

Attachment: Article from September-October 2002 edition of *Health Affairs* entitled "The Growing Challenge of Providing Oral Health Care Services to All Americans; the current practice model of dentistry, which serves insured patients and those who can pay out of pocket, must be changed to include the rest of the population."

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Attachment to ADHA Testimony:

Health Affairs

September 2002 - October, 2002

Title: The Growing Challenge Of Providing Oral Health Care Services To All Americans; The current practice model of dentistry, which serves insured patients and those who can pay out of pocket, must be changed to include the rest of the population.

Author: Elizabeth Mertz and Edward O'Neil

Frustrations over the difficulty of improving health care in the United States often reflect a sense that the system's overwhelming complexity is our worst enemy. In the following overview of the state of the nation's oral health, it is apparent that even in a relatively simple subdomain of the health enterprise, our cherished preference for harnessing private institutions to the pursuit of public goals brings success only at the price of endless tensions and trade-offs.

Elizabeth Mertz and Edward O'Neil find that better preventive care and patient habits have helped improve oral health "for many parts of the population." At the same time, the number of dental hygienists in the workforce has grown steadily and is expected to increase by 37 percent between 2000 and 2010. But the U.S. dentist-to-population ratio declined during the 1990s, and the amount of time that dentists spend with patients every week has also been declining"partly a result of the increasing use of hygienists.

This apparent signal of market equilibrium is misleading. The authors find "abundant evidence that a sizable segment of the population does not have access" to private care, while the dental safety net is "poorly defined and underdeveloped." Dentists' participation in Medicaid is not robust; community health centers and public health facilities have scant dental capabilities; and Medicare offers no dental coverage. "Radical steps" will be needed to correct "a growing disconnect between the dominant pattern of practice8and the oral health needs of the nation," the authors write, including new practice settings for dental care, integration of oral and primary health care, and expanded scope of practice for hygienists and other allied professions.

Mertz is project director at the Center for the Health Professions, University of California, San Francisco (UCSF), and has written and lectured extensively on oral health and workforce issues. She received her master's degree in public affairs from the University of Minnesota. O'Neil is director of the center and a professor of dentistry and public health at UCSF. He is a national authority on workforce issues and holds a doctorate in American studies from Syracuse University.

By many measures, the practice of dentistry has improved for the dentist over the past decade. Hours of work are down, and compensation is increasing. However, there is a

growing disconnect between the dominant pattern of practice of the profession and the oral health needs of the nation. To address these needs, the profession will need to take some radical steps toward redefinition, or the responsibility for many for these needs and special populations may shift to other providers and other institutions.

Dental disease has been widespread, recognizing few barriers of class, ethnicity, or economic status. By the middle of the twentieth century the acute manifestations of caries and advanced periodontitis left large numbers of persons with no options except extensive removal of teeth, restoration of the remaining teeth, and either fixed or removable prostheses. As the profession emerged from the Second World War, it was equipped with the skills for extracting teeth and manufacturing a vast array of mechanical structures fabricated from a variety of materials.

The 1950s witnessed the rise of a much more focused approach to science in all of health care. Through this movement the profession began to understand the systemic causes of infection and disease, which led to more scientific evaluation of existing treatments and new evidence-based approaches to prevention and therapy. Key among the preventive developments was the recognition of the efficacy of fluoride in preventing the onset of disease and the application of fluoride through water supplies as a population health strategy. Also contributing to prevention was the widespread information sharing among dentists, dental hygienists, and educators about the causes of infection and the corresponding change in patterns of self-care and treatment in large parts of the population. New restorative techniques, coupled with the middle-class cultural expectation of the annual dental check-up and the disposable income to pay for these preventive and therapeutic services, led to improved oral health for many parts of the population. [n1]

Although these improvements in oral health are a great success story for the dental profession, science, and the public, patterns of current and incipient oral disease and disability lie outside much of the traditional focus of practice and policy. Emerging concerns for the nation's oral health include access to care for low-income and underserved minority groups, oral diseases related to tobacco use, chronic facial pain, craniofacial birth defects and trauma, and the emergent health needs of an aging population that will need services in new locations and in new forms. [n2] To assess how these epidemiological, social, and economic challenges will confront dentistry, we begin with an assessment of the current dental professional workforce and contrast it, where possible, to the physician workforce.

The Oral Health Care Workforce

There are approximately 150,000 clinically active dentists in the United States. [n3] The number of dentists has been increasing for the past twenty years, but the growth has leveled off in comparison with the growth in the U.S. population, resulting in a decreasing dentist-to-population ratio (Exhibit 1).

Dentist-to-population ratio. From 1950 to 1970 the dentist-to-population ratio hovered at 50 per 100,000. [n4] With increasing demand for dental services and growing state and federal investment in education, there was a sharp rise in the ratio through 1990 when it peaked at close to 60 dentists per 100,000 population. In the late 1970s and 1980s there was a growing perception of oversupply in practitioners by many dental professionals, in both practice and education. [n5] Partly in response to this, applications to dental schools declined sharply during the period. A number of schools closed during this period, and others reduced class sizes. The size of the entering dental class reached an all-time high in 1978 at 6,301, but by 1989 it had fallen by just over a third to 3,979. [n6] This dramatic decline had an almost immediate impact, as dentist-to-population ratios began to fall in the decade of the 1990s. By 2020 this ratio is projected to drop back to 52.7, which translates into one dentist for every 1,898 people. [n7]

In contrast, the physician-to-population ratio has been increasing for the past forty years and now stands at 286 per 100,000, about one physician for every 349 people. [n8] Between 1960 and 1998 the physician population grew by 198.6 percent, while the total population increased only 56.3 percent. Both the physician and dentist ratios vary greatly by region and state.

Age and sex distribution. The dentist workforce is aging, and a good portion will reach retirement age in the next decade. As shown in Exhibit 2, there are fewer young dentists in practice and fewer dentists working past age sixty-five in comparison to physicians. Just 12.5 percent (19,089) of dentists and 38 percent (4,300) of the entering dental students were women in 1996. [n9] In the same year, women were 21 percent (157,387) of the physician population, 35 percent (34,100) of residents/ fellows, and close to 43 percent (6,918) of the entering medical school class. [n10]

Racial/ethnic composition. The racial/ethnic distribution of the dentist workforce is among the least diverse of health professions. Approximately 13 percent of dentists are nonwhite, compared with 22 percent of physicians and 29 percent of the population (Exhibit 3). [n11] Blacks, Hispanics, and Native Americans are generally considered to be underrepresented minorities in the health professions. Dentistry contains 6.8 percent underrepresented minorities, compared with 8.5 percent of physicians and 24.8 percent of the population. [n12] First-year dental students in 1999 were 34 percent nonwhite; however, just 10.2 percent of this entering class were underrepresented minorities. [n13] In medicine, 36 percent of first-year students in 1998 were nonwhite, and 14 percent were underrepresented minorities. [n14]

Workforce size. The dentist workforce is much smaller than the physician workforce. It is growing at a slower rate in comparison to the population, and it tends to be more middle-aged (40-55), more male, and less ethnically diverse.

Practice Characteristics

The vast majority of dentists, more than 80 percent, are in general practice. The remainder are subspecialists, including orthodontists (5.8 percent), oral and maxillofacial surgeons (4.1 percent), periodontists (3.1 percent), pediatric dentists (2.4 percent), endodontists (2.2 percent), public health dentists (0.8 percent), and oral and maxillofacial pathologists (0.2 percent). [n15] This contrasts to the distribution in medicine, where approximately one-third practice the general medicine specialties of family medicine, internal medicine, or general pediatrics. [n16]

Hours worked per week. Private dental practitioners spent an average of 36.5 hours per week in their offices in 1998. Of these, an average of 33.3 hours were spent treating patients; this figure was 33.4 hours for generalists and 33.0 for specialists. [n17] By contrast, physicians in 1999 spent an average of 51.6 hours per week treating patients and an additional 4.7 in other professional activities. [n18]

Full time versus part time. The majority of dentists work full time; however, there has been a trend toward increased part-time work. The number of part-time dentists has increased at a greater rate than the number of full-time practitioners. In 1982 only 14.2 percent of dentists worked part time, compared with 23.8 percent in 1995. [n19] In conjunction with this trend, the average number of hours spent in the office for both full- and part-time practitioners has fallen, although the average number of hours spent treating patients has increased slightly. Therefore, although there has been an increase in overall numbers of dentists in the past few decades, the American Dental Association (ADA) found only "modest gains in the total number of office hours and the total number of treatment hours available to address the dental care needs of all Americans." [n20]

Solo versus group practice. Of all dentists in private practice in 1998, 66.3 percent were solo practitioners working in an incorporated or unincorporated practice. [n21] Generalist dentists (67.3 percent) were somewhat more likely to work in a solo practice than specialists were (61.5 percent). Women made up a larger percentage of non-solo practice dentists (13.9 percent) than solo practitioners (7.6 percent). [n22] An estimated 92 percent of dentists owned their own practices; 76.5 percent were sole proprietors. Most dentists worked in only one office (90.0 percent), while 3.2 percent worked in three or more offices. In contrast, in 1999 only a quarter (25.5 percent) of physicians in active practice were in solo self-employed practice. [n23]

Income. Independent dentists' median net income from all dental sources in 1998 was $135,000"$125,520 for general dentists and $192,000 for specialists. [n24] The median net income, after expenses and before taxes, for physicians in 1998 was $164,000; however, the medians across subspecialties ranged from $120,000 for pediatrics to $205,000 for orthopedic surgeons. [n25]

Patients' characteristics. Of patients in private dental practices in 1998, 21.5 percent were under age fourteen, 58.4 percent were ages fifteen to sixty-four, and 20.2 percent were age sixty-five or older. Almost 56 percent of patients were female. [n26] It is interesting to note the high percentage of patients older than age sixty-five, as this age category

represents only 12.7 percent of the U.S. population. Given that Medicare does not cover dental care and that Medicaid dental benefits are not available in all states even for the elderly who have coverage, this may account for a large portion of out-of-pocket payments. [n27]

On average, 63.7 percent of patients were covered by private insurance in 1998, 5.7 percent were covered by public insurance, and 30.6 percent were uninsured. [n28] In 1998, $53.8 billion in private funds was spent on dental services, nearly half of which took the form of out-of-pocket payments. [n29]

Summary of comparisons. Overall, the practice of dentistry has become a more lucrative and less time-consuming profession over the past decade. In comparison to physicians, dentists work more independently, have a higher rate of solo practice, and have greatly increased their earnings, in some cases surpassing the net income of physicians. Dentistry has remained a "cottage industry," which has fought incorporation into larger systems of managed care and capitated payments that have permeated medical groups.

The Allied Dental Health Workforce

Hygienists. Dental hygienists are licensed health care professionals who provide preventive, educational, and therapeutic services for the control of oral diseases and the promotion of oral health. All registered dental hygienists (RDHs) graduate from a minimum two-year college program that includes classroom studies and supervised clinical experience. Dental hygienists also must pass a national written exam and a state clinical exam to earn the RDH license. Most dental hygienists practice as independent contractors, and many work part time or for more than one practice. The Bureau of Labor Statistics (BLS) estimated that more than 90,000 hygienists practiced in the United States in 2000, with a mean salary of $48,150. [n30]

Assistants. Dental assistants work chairside with the dentist, in the business office, and in the dental laboratory. Many states do not require formal training or licensure for dental assistants. However, there are many certified dental assistant training programs, mostly at the community college level, as well as expanded practice dental assistant certifications in many states. The BLS estimates that there were 175,160 dental assistants employed in the United States in 2000, with an average salary of $24,130. [n31]

Laboratory technicians. Dental laboratory technicians are responsible for filling prescriptions from dentists for bridges, dentures, crowns, and other dental prosthetics. According to the BLS, dental technicians held about 43,000 jobs in 2000, mostly in small dental laboratories. The average salary for a dental technician was $26,915. [n32] Formal training for this profession is available primarily through community and vocational programs; however, most dental technicians learn their trade "on the job." In 2000 there were thirty accredited programs in the United States, although in most states

certification is not mandatory. [n33]

Job growth The rate of growth in new jobs in health care occupations is projected to be 28.8 percent between 2000 and 2010. However, among the five health occupations with the lowest rate of growth are dentists (5.7 percent) and dental laboratory technicians (6.3 percent). In contrast, the number of hygienist jobs will grow by 37.1 percent. [n34]

Approximately 62 percent of solo dentists employed at least one part-time or full-time dental hygienist in 1998, compared with 54 percent in 1986. [n35] Dentists in nonsolo practice tended to employ more hygienists; only 16 percent employed no hygienist. Also, 93.4 percent of all solo general practice dentists employed at least one dental assistant. All nonsolo practices had at least one dental assistant, and more than half employed three or more. [n36]

The projected growth in hygiene positions may indicate a trend for dentists to use more auxiliary staff for preventive and basic restorative care so they can concentrate on more specialized, highly reimbursable procedures. However, although the use of auxiliary staff has increased, these workers are more likely to be employed in group settings or practices, which are still relatively uncommon in dentistry. An increasing number of states are exploring expanded practice rights for dental hygienists, usually for the purpose of providing preventive care for underserved populations. This is allowable by law in only a few states, and independent hygiene practice is still relatively rare.

Dental Services In the Public Health Sector

There is abundant evidence that a sizable segment of the population does not have access to dental care through the traditional private practice model. [n37] Yet there is a poorly defined and underdeveloped dental "safety net." The result is that a growing number of people, many of them children, are unable to get regular dental care through the dental public health system or any other way.

The Health Resources and Services Administration (HRSA) estimates that in 1998 there were only 2,032 public health dental workers employed in federal or state agencies. [n38] These workers are responsible for planning, developing, implementing, and evaluating programs to promote and maintain the oral health of the public. Functioning at the federal, state, and local levels, these public health workers are defined officially only by their training in dentistry or dental health. Additional public health staff may work on dental public health issues but under a different official title. The release of Healthy People 2010 and the surgeon general's report on oral health, which discussed the disparate burden of oral disease on the underserved, stimulated more interest in public health dental programs. However, to staff these programs with professionals willing to work in the public sector with underserved populations is an ongoing challenge. [n39]

There are relatively few public health dentists in the United States. Just 0.8 percent of

professionally active dentists in 1998 were public health specialists, approximately 1,207 dentists. [n40] In addition, approximately 400 dentists (in 2002) work for the Indian Health Service, and 258 are serving in the National Health Service Corps. [n41] While some dentists volunteer their time to help the underserved, the lack of dentists participating in Medicaid continues to be a major access barrier for many low-income populations. [n42] Community health centers (CHCs), serving 8.6 million people, including 2.8 million Medicaid beneficiaries, were only able to provide 1.2 million patients with preventive and basic dental care in 1998, less than 13 percent of the total clientele. [n43] Dentists actively fought any Medicare dental benefit when the program was created in the late 1960s. Unless this lack of coverage changes, baby boomers soon reaching retirement age will be faced with no systematic way to finance their dental care.

RDHs, with their occupational growth and focus on preventive care, may be the oral health professionals best poised to address issues of access. However, RDHs are restricted in most states from practicing without a dentist's supervision. The growing shortage of dentists in many areas limits hygienists' ability to provide preventive care where it is needed most. The low priority of dental public health within public funding mechanisms has also restricted full-scale prevention activities in schools and health care facilities. While many benefit from fluoridated water, only those who can afford regular dental care receive the benefits of regular, comprehensive preventive care.

Current Crisis Of Care

The recent surgeon general's report cataloged the advances that have been made in the technology and science of oral health care but also clearly showed that there are worsening disparities in the oral health status for certain population groups. Underserved groups include people who are low-income or indigent; live in rural communities; are racial or ethnic minorities, non-English speaking, children, or elderly; and are developmentally disabled or have major medical problems. [n44] Each of these populations faces sizable barriers to care, and all are at a notable disadvantage with poorer health outcomes. Socioeconomic status tends to be the most important indicator for use of services and health outcomes, regardless of race and gender, while people with dental insurance have a higher likelihood of visiting a dentist than do those without. [n45]

In no small measure, this is attributable to the current practice model of dentistry, which is structured to serve insured patients or patients who have the disposable income to pay for services out of pocket, in areas served by dental providers. Moreover, dental education trains new providers within the current practice model, leaving little room for developing a different type of practitioner that might appropriately address unmet needs. There is limited public financing for oral health care services outside of private dental offices. The dental safety net is small compared with the medical safety net, and many safety-net providers are underfinanced, understaffed, and overburdened. [n46]

Practitioners operating in the traditional delivery service model are able to sustain and increase income while working shorter hours, so they have little financial incentive to modify their practice. This lack of incentive, the limited supply of dentists, and the lack of alternatives for delivery and financing of care mean that much of the population with the greatest and fastest-growing set of needs will continue to be underserved by the traditional system of private practice, fee-for-service dentistry.

Alternatives To Current Practice

A system of dental care that will begin to address the unmet health needs of a growing part of the population will likely need to move beyond the existing system of finance, practice organization, and professional utilization. [n47] The standard response to the lack of dental services is to suggest increasing the number of dentists. Some increase may be warranted, and perhaps inevitable, but it may be more useful to understand this problem less as a problem of supply of practitioners and more as a poor fit between part of the current practice model, the patterns of disease, and the people needing care. Such a change will raise several critical questions, such as the following: Where do those who have the greatest oral health needs receive other health care? What physical and financial impediments could be removed to facilitate meeting current and future demand? Are there social service or employment settings that might effectively sponsor oral health services? What motivations might bring the underserved more seamlessly into a system of care? How can expectations regarding oral health be raised within the under-served population?

Alternative organizational structures. A variety of strategies have been explored to provide some level of improved access to dental care for underserved populations. [n48] On the supply side, public dental clinics, whether freestanding or integrated into larger medical clinics, represent the closest alternative to private practice. Dental vans and mobile dental services have become a popular solution for delivering services to rural communities or schools. Increasingly, school-based or -linked services organize care at easily accessible sites and emphasize preventive care and screening. Teledentistry enables dentists in remote clinics to communicate with specialists in urban centers, to provide better diagnosis and referral. [n49]

Increased education about programs. Alternative organizational structures of dental services are only a part of the equation. Many communities have historically underused dental services. To increase participation in oral health care, focused population-targeted programs concentrate their efforts on increasing education and awareness about services within specific population groups. Some programs go further, providing case management for their clients to ensure proper screening, treatment, and follow-up. [n50] Policy responses to increasing the supply of and demand for dental services must move beyond funding the traditional models of Medicaid coverage and provider incentives to take more charity cases. A sound policy response would vastly expand the dental public health infrastructure to creatively bring those with unmet need into a system of care.

Integrating oral and primary health care Another model of care focuses on the reintegration of oral health care into primary health care. This concept is being explored in both the dental and medical communities. [n51] One of the keys to improving access to care is making dental services visible, affordable, and convenient for underserved populations. Primary care medicine has more routine contact with these populations, providing opportunities for preliminary dental screening and education as well as integration of clinical services.

Any strategy to address the barriers to care will need to be a collaborative effort across health care providers, as no single profession can tackle the issue alone. [n52] For example, the monitoring of oral health could be incorporated into a chronic care model and be offered in systemic primary care carried out by family physicians. [n53] This would be beneficial to Medicare recipients who have no dental coverage. Addition of a dental benefit to Medicare is unlikely in the current fiscal environment, and to date alternative public mechanisms to finance dental care for the elderly are not in sight. Although access to care for underserved populations is on the policy screen, the important issues associated with dental care for the elderly have yet to catch policymakers' attention.

Multidisciplinary approach. The public health system has not been competitive in attracting dentists, so the use of a variety of health professionals and social workers should be considered. Multidisciplinary efforts may better reach under-served populations by combining administrative efforts and public health goals.

Expanded practice for hygienists and assistants. Expanded practice for dental hygienists and assistants is another option being explored as a way to increase access to preventive services and education. [n54] Pilot studies have shown the expanded practice models to be safe and effective, and these practices have been successful in reaching underserved populations. [n55] Regulatory change around scopes of practice is a slow process, and few states have implemented major changes. Expanding the roles of allied oral health practitioners could increase the contact points for oral health information and care for numerous populations.

New dental school strategies. It is unlikely that the current dental workforce will be adequate to meet the oral health needs of our communities; therefore, the pipeline for providers is an important issue that must be addressed. [n56] Dental schools could recruit and support more students from underserved backgrounds, who have been shown to be more likely to work in underserved communities. [n57] Education programs also should encourage all oral health providers to serve under-served communities throughout their professional careers. Similarly, an expansion of dental hygiene and dental assisting education may increase the raw supply of these practitioners, but only if this effort is combined with regulatory change that ensures full use of their skills.

Program evaluation. While experimental interventions to increase demand and alter the structure and financing of care hold promise, evidence of effectiveness is still nascent.

For the most part, safety-net programs focus on meeting the enormous volume of demand for services rather than dissipating resources to evaluation. A focused effort on program evaluation, with concentration on cost-effectiveness and patient outcomes, is an important final step for alternative models to gain legitimacy and support. Alternative programs remain a small fraction of all dental services.

Meeting the challenges of reducing disparities in oral health care will require fundamental redefinitions of how dental practice is organized, financed, and provided. In the long run, it would seem that systems of oral health care must be either directly integrated into larger systems of care or more effectively articulated with them. Financing of care must be realigned to pay for proven and effective interventions. Finally, the education of dental professionals must focus on community health and well-being, in addition to individual treatment and private practice.

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REFERENCE:

[n1.] A.B. White, D.J. Kaplan, and J.A. Winetraub, "A Quarter Century of Changes in Oral Health in the United States," Journal of Dental Education 59, no. 1 (1995): 19-60.

[n2.] W.D. Hendricson and P.A. Cohen, "Oral Health Care in the Twenty-first Century: Implications of Dental and Medical Education," Academic Medicine 76, no. 12 (2001): 1183-1185.

[n3.] American Dental Association, Survey Center, The 1999 Survey of Dental Practice (Chicago: ADA Press, 2000).

[n4.] R.W. Valachovic et al., "Trends in Dentistry and Dental Education: 2001," Journal of Dental Education 65, no. 6 (2001): 539-561.

[n5.] E.H. O'Neil and B.D. Barker, "Pew National Dental Education Program Developing an Agenda for Change," Journal of Dental Education 53, no. 8 (1989): 469-474.

[n6.] Valachovic et al., "Trends in Dentistry and Dental Education."

[n7.] Ibid.

[n8.] American Medical Association, Physician Characteristics and Distribution in the U.S., 2000 Edition (Chicago: AMA, 2000).

[n9.] ADA, Survey Center, Distribution of Dentists in the United States by Region and State, 1996 (Chicago: ADA, 1998); and Valachovic et al., "Trends in Dentistry and Dental Education."

[n10.] AMA, Physician Characteristics and Distribution in the U.S.; and Association of American Medical Colleges, "FACTS"Applicants, Matriculants, and Graduates," 24 October 2001, www.aamc.org/data/facts/ famg72001a.htm (9 May 2002).

[n11.] ADA, Survey Center, Distribution of Dentists; AMA, Physician Characteristics and Distribution in the U.S.; and U.S. Bureau of the Census, "Resident Population Estimates of the United States by Sex, Race, and Hispanic Origin: April 1, 1990 to July 1, 1999, with Short-Term Projection to November 1, 2000," eire.census.gov/ popest/archives/national/nation3/intfile3-1.txt (8 May 2002).

[n12.] Ibid.

[n13.] Valachovic et al., "Trends in Dentistry and Dental Education."

[n14.] AAMC, "FACTS"Applicants, Matriculants, and Graduates."

[n15.] ADA, Survey Center, Distribution of Dentists.

[n16.] AMA, Physician Characteristics and Distribution in the U.S.

[n17.] ADA, Survey Center, The 1999 Survey of Dental Practice.

[n18.] AMA, Physician Characteristics and Distribution in the U.S.

[n19.] L.J. Brown and V. Lazar, "Workforce Trends That Influence Dental Service Capacity," Journal of the American Dental Association (May 1998): 622.

[n20.] Ibid.

[n21.] ADA, Survey Center, The 1999 Survey of Dental Practice.

[n22.] Ibid.

[n23.] J.D. Wassenaar and S.L. Thran, eds., Physician Socioeconomic Statistics, 2000-2002 Edition (Chicago: AMA, 2001).

[n24.] ADA, Survey Center, The 1999 Survey of Dental Practice.

[n25.] AMA, Physician Socioeconomic Statistics, 1999-2000 Edition (Chicago: AMA Press, 1999).

[n26.] ADA, Survey Center, The 1999 Survey of Dental Practice.

[n27.] U.S. Bureau of the Census, "Resident Population Estimates."

[n28.] ADA, Survey Center, The 1999 Survey of Dental Practice.

[n29.] Centers for Medicare and Medicaid Services, Health Care Financing Statistics (Baltimore: Office of the Actuary, National Health Statistics Group, 2000).

[n30.] Bureau of Labor Statistics, 1999 Occupational Employment and Wage Estimates, February 2002, www.bls.gov/ oes/1999/oes-29He.htm (9 May 2002).

[n31.] Ibid.

[n32.] BLS, Occupational Outlook Handbook, 2002-03 Edition, www.bls.gov/oco/home.htm (9 May 2002).

[n33.] Ibid.

[n34.] Center for Health Workforce Studies, Health Care Employment Projections: An Analysis of Bureau of Labor Statistics Occupational Projections, 2000-2010 (Rensselaer: University at Albany, State University of New York, School of Public Health, January 2002).

[n35.] ADA, Survey Center, The 1999 Survey of Dental Practice.

[n36.] Ibid.

[n37.] E.A. Mertz et al., Improving Oral Health Care Systems in California: A Report of the California Dental Access Project (San Francisco: UCSF Center for the Health Professions, 2000); and Department of Health and Human Services, Oral Health in America: A Report of the Surgeon General (Rockville, Md.: DHHS, 2000).

[n38.] K. Gebbie, The Public Health Workforce Enumeration 2000 (New York: Center for Health Policy, Columbia University School of Nursing, and Bureau of Health Professions, Health Resources and Services Administration, 2001).

[n39.] Mertz et al., Improving Oral Health Care Systems in California.

[n40.] ADA, Survey Center, The 1999 Survey of Dental Practice.

[n41.] Indian Health Service, "Indian Health Service Dental Program," www.ihs.gov/MedicalPrograms/Dental/index.asp (8 May 2002); and Stan Bastacky, MHSA acting chief, Dental and Special Projects Branch, Division of Medicine and Dentistry, Bureau of Health Professions, HRSA, personal communication, 1 May 2002.

[n42.] U.S. General Accounting Office, Factors Contributing to Low Use of Dental Services by Low-Income Populations, Pub. no. GAO-00-149 (Washington: GAO, 2000).

[n43.] DHHS, Oral Health in America.

[n44.] Ibid.

[n45.] R.J. Manski and L.S. Magder, "Demographic and Socioeconomic Predictors of Dental Care Utilization," Journal of the American Dental Association (February 1998): 195-200.

[n46.] North Carolina Institute of Medicine Task Force on Dental Care Access, Report to the North Carolina General Assembly and to the Secretary of the North Carolina Department of Health and Human Services (Durham: North Carolina Institute of Medicine, 1999); and Minnesota Department of Human Services, Dental Access Services Report (St. Paul: Minnesota Department of Human Services, 1999).

[n47.] D. Grembowski, A. Ronald, and C. Meei-shai, "A Public Health Model of the Dental Care Process," Medical Care Review 46, no. 4 (1989): 439-497.

[n48.] R.C. Warren, Oral Health for All: Policy for Available, Accessible, and Acceptable Care (Washington: Center for Policy Alternatives, 1999).

[n49.] Mertz et al., Improving Oral Health Care Systems in California.

[n50.] Ibid.

[n51.] M. Drum, D. Chen, and R. Duffy, "Filling the Gap: Equality and Access to Oral Health Services for Minorities and the Underserved," Family Medicine 30, no. 3 (1998): 206-209.

[n52.] DHHS, Oral Health in America.

[n53.] E.H. Wagner, "Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness?" Effective Clinical Practice 1, no. 1 (1998): 2-4.

[n54.] Dental Health Foundation, Oral Health Access Council, personal communication, 8 May 2002.

[n55.] J.R. Freed, D.A. Perry, and J.E. Kushman, "Aspects of Quality of Dental Hygiene Care in Supervised and Unsupervised Practices," Journal of Public Health Dentistry 57, no. 2 (1997): 68-75.

[n56.] Valachovic et al., "Trends in Dentistry and Dental Education."

[n57.] E.A. Mertz and K. Grumbach, "Identifying Communities with Low Dentist Supply in California," Journal of Public Health Dentistry 61, no. 3 (2001): 172-177.

TESTIMONY

Of

Jonathan Musher, MD

On behalf of the

American Health Care Association

U.S. Senate Special Committee on Aging
September 22, 2003

Good afternoon Senators Craig, Breaux, and members of the Committee. I appreciate the opportunity to be with you here today -- and to provide you with perspective and insight on the oral health care needs and requirements of our nation's frail, elderly and disabled.

My name is Dr. John Musher and I am Director of Medical Services for Beverly Health Care Corporation. I speak today on behalf of the American Health Care Association (AHCA). We are a national organization representing some 12,000 providers of long term care, and employing more than 1.5 million caregivers.

I'd like to thank the Chairman for calling this important hearing, as it provides the long term care community the opportunity to outline what we are doing to help improve the quality of our patients' oral health, discuss some of the chronic systemic problems we face, and to underscore the necessity of stepping up preventative care.

I have been in the care giving profession for many years, and am keenly aware that good oral health care is a prerequisite to one's overall health status, and the two cannot be viewed in isolation.

Oral health in the elderly is of the utmost importance to providers. Proper assessment and intervention is critical to quality care and the quality of life of our patients. Lack of oral health can often lead to other problems such as difficulty eating, malnutrition, pain, depression, weight loss, and even skin breakdown. Residents with dementia are particularly challenging to treat, and the scarcity of dentists in long term care poses a challenge.

Mr. Chairman, I would like to impress two points upon the committee and the stakeholders assembled here. First that oral health in the elderly is an issue providers take very seriously, and second, that we need a collaborative approach to addressing the challenges that impede the timely assessment and treatment of oral health problems in the elderly.

Our goal must be to better assess oral health problems, bolster staff training to identify and treat problems, and increase patient access to quality dental care.

Currently, all nursing home patients are assessed by nursing staff on a routine basis for chewing and swallowing problems. This assessment is part of the current MDS, Section K Oral/Nutritional Status. The MDS full assessment looks for chewing problems, swallowing problems and mouth pain.

The Section L, Oral/Dental Status questions of the current MDS Full Assessment, under L1, includes the following:

- Checking for debris (soft easily movable substances) present in the mouth prior to going to bed at night;
- Assessing whether a patient has dentures or a removable bridge;
- Evaluating the extent of some or all natural teeth lost;
- Checking for broken, loose, or carious teeth;
- Evaluating the possibility of inflamed gums, swollen or bleeding gums, oral abscesses, ulcers or rashes, and,
- Ensuring the daily cleaning of teeth/dentures or daily mouth care-by resident or staff.

Regarding matters related to reimbursement, Mr. Chairman, care provided by a dentist is covered under Medicare Part B -- yet patients must have supplemental coverage to pay for what Part B does not pay for. If the patient does not have a supplemental plan, then the patient may pay out-of-pocket, or when this is not possible, the facility often has to pay.

With regard to Medicaid – the payment source for nearly 70% of nursing home residents - many states do not cover dental services at all. Not coincidentally, those states where Medicaid does not cover dental services, or has limited coverage are the states where access to dental services is the biggest problem. To make matters worse, many states are proposing or planning on reducing this coverage to deal with their budget shortfalls.

Many states cover emergency care only. This poses a major problem when residents are admitted with years of neglected oral care and states will not classify needs as emergency. Also, in many states, including Louisiana, only dentures are covered, and examination is only covered when in conjunction with denture construction. This leaves many more treatable needs unmet because no one can pay for the service. Nevertheless, nursing homes are required to meet the dental needs of their residents.

It is another classic example of government nursing home standards requiring services, and then not paying for them. The lack of payment creates a major access problem in the states that will not pay for services.

We face a variety of challenges when it comes to maximizing access to dental care, including the fact some facilities – especially in more isolated, hard to reach rural areas -- cannot find a consultant dentist to provide services at the facility. In addition, some facilities may not be equipped with a dental suite with which to accommodate a consultant dentist.

Some of the common patient issues we encounter, Mr. Chairman, include:

- Patients not wearing or refusing to wear their dentures;
- Patients losing or misplacing their dentures. This is a problem for families since replacing dentures are costly. As a result, the replacement of lost dentures can often become the basis of a general liability claim;

- Patients with dementia will sometimes take and wear another patient's dentures, which is often a primary cause for ill-fitting or lost dentures;

- Also, patients who are confused or have dementia or psychiatric issues may not allow a visual or manual examination of the mouth, and, for years, may have had a poor adherence to good oral hygiene. Unfortunately, many patients have become accustomed to not wearing their dentures and refuse to wear them when recommended by staff, physician, dentist and even family members.

While there are obvious cost implications associated with stepped up monitoring and better training, the benefits of oral care go far beyond simple economics: improved taste perception, food enjoyment, social interaction and, indeed, quality of life itself.

Collaboration is a key to improving assessment, access to care, and reimbursement issues.

From a big picture standpoint, we need to work collaboratively not just to improve the accuracy and consistency of the survey process in the context of oral health, but also encourage facilities to adopt quality assessment and improvement systems.

We have been working collaboratively with CMS, ADA, and other stakeholders to improve assessment skills and protocols with regard to oral care. These efforts are yielding increased understanding on the part of government and cooperation among the multiple disciplines that treat the elderly.

These collaborative efforts must be expanded to address issues of access and payment, treatment, and training. This type of collaborative approach is how we successfully reduced use of restraints, and addressed malnutrition through the Nutrition Screening Initiative (NSI). I would just add that the Federal and State governments – as the major payor source must not abdicate its responsibility to pay for the services our elderly require.

Clearly, Mr. Chairman, the status quo as it relates to dental care and the survey process needs improvement. While adhering and working to improve our survey process on one hand, we also believe that quality improvement and associated systems must be resident-centered. They must be based on solid, well-understood policies and procedures and resident care protocols that enable the facility interdisciplinary team to monitor both clinical conditions and the processes of care that will lead to improved oral health outcomes for residents.

In conclusion, Mr. Chairman and Members of this Committee, I can say that there has never been a broader recognition of the importance of quality or a broader commitment to work to improve it on a comprehensive basis.

The remarks and observations of all here today underscore the fact that sound oral health is just as important as every other facet of care. We, as providers, know that we must lead in improving care quality, public trust and customer satisfaction – and we look forward to working with you on a permanent, ongoing, collaborative basis to do so.

Chairman Craig, Senator Breaux, Senators _____, distinguished members of the panel, and guests – I am profoundly honored to be here today at this hearing. Along with my associate and friend Dr. Folse, I feel that as a dentist who has worked with Louisiana's program for the last 10 years and as an educator who has devoted countless hours studying and debating policy issues on a state and national basis, that I represent the dentists of America in this battle for appropriate and necessary access to care for optimum oral health for this deserving cohort of our population, many of whom have great need.

I was shocked to receive an invitation to participate, and immediately contacted the committee staff to find out why me. I was informed that I was to serve as a spokesman for all of the Medicaid programs throughout America. What a tremendous honor and responsibility. How could I possibly impart the triumphs, the needs, and the problems of so many varied programs? How can I answer the question asked by the committee – What are the greatest problems that America's seniors face where oral health is concerned?

I can tell you that nationally, programs for adult Medicaid have been brought into sharp focus the past two years. About two years ago there was talk that finally "the stars were aligning" for the overall improvement of oral health in America – Surgeon General Satcher's Report on Oral Health in America released in 2001 was followed in early 2003 by Surgeon General Carmona's National Call to

Action to Promote Oral Health. These followed the 1995 study by the IOM of dental education and a later IOM panel that studied the possible inclusion of partial dental coverage in Medicare for patients with certain diseases that are adversely impacted by oral conditions. Similarly within very recent times we have been informed of the relationship between oral health and low birth weight babies, oral health and diabetes, and oral health and cardiac disease.

Why do these problems exist? Unfortunately for adults, including the elderly enrolled in Medicaid throughout the states, the stars' alignment has turned into a sort of eclipse due to the serious and severe budget shortfalls experienced in many statehouses.

Why the disproportionate impact on adult dental programs? Because under Title XIX of the Social Security Act (Medicaid), dental care, except for that mandated in the EPSDT Program for children, is an optional service. When the dollars are tight, optional services are sliced. The committee asks if ageism is involved or neglect or a lack of societal awareness. In my opinion its not overt neglect, or societal indifference, or even ageism, but something I'll term "teethism". A lack of proper oral health is not seen as a true health need nor is it properly funded even when included. A survey of state programs for Adult Medicaid in April of 2003 received responses from 29 states – only 10,000,000 adult lives (of all ages) were covered and an average of less than $100.00 was spent per enrollee. Try to

get your teeth examined, x-rayed and cleaned for less than $100.00, much less have any teeth filled or receive any type of periodontal treatment.

But I do see a light at the end of the tunnel. I believe the stars are still aligned – why? Well for starters, my state, Louisiana actually slightly increased its budget for the Adult Program in this fiscal year. In many other states where the adult programs were threatened with elimination or severe cutbacks, advocates for oral health were able to stave off either the elimination or reduce the scope of the cutbacks. The directors of Medicaid dental programs are speaking to each other, exchanging ideas that have worked or are working, and have even formed a national association. Add to this the increasing realization by physicians and dentists as well as the population in general that the mouth actually is part of the human body and should be treated and receive appropriate medical and dental care as such. Finally, baby boomers are, unlike the generations of Americans before them, keeping their teeth as they age and they are going to demand that the dental profession and those who pay the bills (Medicaid and Medicare among them) step up to the plate. I hope they hit a homerun.

Thank you for listening to me.

Do I have any recommendations or solutions for these problems?

Yes I do, I only hope that this committee can help to implement them.

Oral health must be recognized as an essential part of over all health. Treatment for oral conditions must be as readily available as treatment for medical conditions.

Funds must be available to underwrite the cost of this care. The mechanism for patients accessing the care and for the healthcare professionals receiving reimbursement for delivering the care must be similar to for this population, if not essentially the same as, the mechanism for the population as a whole.

Medical and dental professionals must be competent in recognizing and orchestrating treatment for oral conditions in this population.

Successful programs must be replicated in new locales. We must learn from our successes as well as from our mistakes. I believe that Medicaid of Louisiana and the elderly residents of our state have profited greatly from the relationship that the LSUHSC School of Dentistry through its Department of Dental Health Resources has enjoyed with the Department of Health and Hospitals. This blending of expertise has resulted in sound policy decisions

that have been beneficial to all concerned. In every state, all of the stakeholders in this situation must talk and share ideas – as a teacher I greatly respect told me many years ago – "none of us are as smart as all of us." All of us must work together.

Thanks you.

Statement of

ROBERT J. KLAUS
President and CEO
Oral Health America

Forum: Senate Special Committee on Aging
"Ageism in Health Care: Are Our Nation's Seniors Receiving Proper Oral Health Care?"

September 22, 2003

Chairman Craig, Senator Breaux, and distinguished Members of the Senate Special Committee on Aging, good afternoon. My name is Robert Klaus, and I am the President and CEO of Oral Health America, the nation's only independent organization devoted to oral health. Our mission is to raise awareness of oral health's importance to total health. I join my colleagues in the oral health community today to put the oral health of older Americans on the radar screen.

I wish to thank the Committee for bringing this important, but overlooked health issue to the table. Oral health and overall health have had separate chapters in our nation's history for far too long. But keeping America healthy will require a more systemic approach. Oral health is a lifetime factor critical to overall health, and as we make decisions about the future of health care, oral health and oral health care must be included.

Good oral health care should begin at birth. This important component of health care should not—and cannot—end at retirement. Proper dental care must be a lifetime commitment. Unfortunately, for far too many older Americans, oral health care is a luxury. Too many of our "greatest generation" suffer from chronic oral pain and disease, severely limiting regular activities of daily living and impeding their independence. Neglect of oral health may result in the deterioration of overall physical health. Lack of access to care for even routine dental

cleanings and exams can exacerbate serious and complicated overall health problems that increase with age.

Limited access to oral health care poses one of the greatest crises for the health and well being of America's elderly. Oral Health America released a report today titled, "A State of Decay: The Oral Health of Older Americans," which grades states on oral health coverage for older adults. Our national grade is an embarrassing "D." A State of Decay reflects the poor condition of the oral health of older Americans, a state in which approximately one out of every three have no teeth. This report card reflects a misguided system of care that would more readily commit an older person to a nursing home than provide cost-effective routine dental care that would help some continue to live a healthy, independent life.

Why are we doing so poorly? There is, to begin with, the problem of insurance, or more precisely, the lack of insurance.

Less than 20 percent of Americans 75 and older have any form of private dental insurance. Medicare and Medicaid are of no and little hope respectively. Not one older American receives routine dental care under Medicare. Under Medicaid, adult dental care is optional and 27 states are failing to meet even the most minimal standards of care. Often enough, the first casualty of tough times for state governments is the oral health provisions of Medicaid. This year, we have seen a continued erosion of adult Medicaid dental benefits, most recently highlighted by Michigan's decision to cover emergency benefits only. Medigap, used by some older Americans as a supplemental insurance to Medicare, is an expensive cavity when it comes to dental coverage.

Older adults experience the cumulative toll of oral diseases over their lifetime. This results in extensive oral disease. Surveys have shown that nursing home residents with teeth

suffer particularly from untreated tooth decay, while those without teeth also have a variety of oral health problems. Medications often adversely affect oral health as well.

Some older Americans—especially those with special needs, the frail, and those classified by the Social Security Administration to be aged, blind and disabled—are often plagued with challenging oral health needs. Being disabled, medically compromised, homebound, or institutionalized increases the likelihood of serious dental problems and limited access to dental care. Our national grade may be a "D" for older Americans overall, but when it comes to caring for vulnerable populations the country is flat out failing. Fourteen states and the District of Columbia received F's for older adult dental coverage and 29 others received D's. The highest grade was only a C+, shared by California and New York.

In addition to financial barriers, there is a constellation of problems, including the distribution and supply of oral health practitioners, administrative and bureaucratic barriers and the cluster of issues around scope of practice.

Lack of access to oral health care is compounded by a shortage of skilled geriatric dental care professionals, part of a larger national shortage of geriatricians described to the U.S. Senate Special Committee on Aging by the Alliance for Aging Research in their report, *Medical Never-Never Land.* Just finding a dentist can pose a considerable challenge for older Americans and those with a disability. The good work of community health centers is limited to providing preventative and basic dental care to only about one-in-twelve patients who are fortunate enough to have access to such a facility. In many states that provide a dental benefit, reimbursement rates are too low to attract a sufficient number of dentists willing to treat Medicaid patients. The challenge of finding a dentist in a nursing home is a systematic nightmare, despite an existing federal mandate and standards of care.

Unmet oral health needs for older adults continue to grow. According to the American Dental Association, oral health needs eclipse those of medicine and surgery by over 50% (JADA, June 1998). Oral Health America anticipates that this situation is going to worsen appreciably in the foreseeable future.

Ageism has played a subtle but compelling role in limiting access for older Americans. Many government initiatives and policy solutions in oral health have focused children. At the state level, expanded Medicaid, SCHIP, and EPSDT services have provided more opportunity for low-income children to see a dentist, and receive the routine and preventive care they need. Children's oral health has been the focus of well-crafted national legislation.

But it has been harder to engage people on the oral health of older adults. Why? There very wall maybe a societal acceptance that senior citizens do not necessarily need their teeth, or can or should have a healthy mouth. Vulnerable older adults are not always the best self advocates. Oral health is at best a secondary health consideration by caretakers, and when no insurance coverage exists to provide even basic procedures, when there's no infrastructure to support routine and preventive care, millions suffer in silence.

This forum is a major step in overcoming perhaps the greatest barriers to improved oral health: silence and indifference. Former U.S. Surgeon General Dr. David Satcher has called the oral health crisis a "silent epidemic." This forum and the good work of this Committee, Senator Breaux and other leaders are positive steps in finding solutions.

Yet, it's not just legislators who are unaware of this problem. The Frame Works Institute (December 1999) put it more baldly and boldly: "You cannot solve a problem that is not perceived to exist by the public. To say that this issue has not emerged in public discourse is to greatly understate the issue; it is <u>invisible</u>."

Emergent in this vacuum of silence and visibility is a failure of imagination and leadership for which we must all be held to account, both as representatives of organizations or institutions that can do something about it, and as individuals as well.

For me, the silence of this epidemic was broken almost 15 years ago when I would visit my late father, an Alzheimer's victim, in the nursing home. It was enough to bear the twilight of his personality and identity without having it so graphically manifest in a mouth that expressed pain even as it spoke of indignity.

Despite America's improving oral health, it is likely that all of us have been touched by the unmet oral health needs of a family member, friend, colleague, or acquaintance. I ask you to keep those stories, and the stories you will hear today from Dr. Greg Folse close at hand as we consider solutions to problems of access to oral health for our nation's elders.

Prevention plays a significant role in keeping Americans healthy and happy, but we must also recognize that unmet treatment needs of our population are not going to go away, and are costing the country billions of dollars annually. The price to fix them is relatively small, and well within our capabilities.

Thank you for your time.

United States Senate Special Committee on Aging
September 22, 2003

Testimony of Dr. Paul Glassman DDS, MA, MBA,
Associate Dean, Co-Director Center for Oral Health for People with Special Needs
University of the Pacific School of Dentistry
President, Special Care Dentistry

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Chairman Craig, Senator Breaux, and distinguished Members of the Senate Special Committee on Aging, it is a pleasure and an honor to be able to bring you some information about the oral health of seniors and people with disabilities in our country.

I am here as President of Special Care Dentistry. Special Care Dentistry is the only National membership organization devoted to promoting oral health and well being for people with special needs.

Special Care Dentistry has three components: the American Association of Hospital Dentists; the Academy of Dentistry for Persons with Disabilities; and the American Society for Geriatric Dentistry. The reason these three, formerly separate, organizations came together to form Special Care Dentistry is because their members recognize how similar the oral health problems are for the people they serve. This is true whether a Special Care Dentist is someone providing oral health care in a hospital, or someone serving people with disabilities or frail elderly individuals in community setting or nursing home. The financial, physical, medical, or behavior challenges that these individuals may have, has resulted in a nationwide crisis with little or no access to preventive and treatment oral health services.

I want to briefly bring you one story that illustrates what can happen when oral health is neglected. Sarah and her mother could not be here today so I am bringing this story to you electronically. The attached transcript is of a five minute video tape called "Sarah's Story."

Sarah's story illustrates some of the financial and emotional consequences of poor oral health. There is also increasing evidence of the correlation between oral health and systemic disease. Poor oral health is correlated with: coronary artery disease (some studies show four times the risk of death for people with severe periodontal disease); Diabetes; premature delivery and low birth weight; failure to thrive; ischemic stroke; brain abscess; bacterial endocarditis; and respiratory diseases.

So, given the terrible consequences that result from not having dental treatment, why don't people who are disabled and elderly receive the services they need? One factor is the trends in the dental health workforce. Many dentists are busy treating people who don't have financial, physical, medical, or behavior challenges, who they feel better trained to treat, and who they feel more comfortable with.

We know that the dentists retiring today graduated at a time when there were 6000 graduates from dental school each year. They are being replaced with today's 4000 graduates. In spite of these numbers, and in the face of an increasing population, it is still controversial as to whether we are facing a severe dentist shortage or not. I want to point out, as this committee and others analyze this situation, that all the estimates about the dental workforce we have and we need are based on the assumption that those members of our society who are not currently receiving dental services will continue not to receive dental services.

We also need to realize that the availability of dentists trained and willing and able to treat people with special needs is only a part of the problem. There is a general lack of awareness of the importance of dental health and the consequences of dental disease among general health and social service professionals and among caregivers and people with special needs themselves.

There are many innovative systems that have been developed to address these problems. I had the privilege of presenting one of eight "models that work", and the only one addressing oral health issues, at the Surgeon General's Conference on Health Disparities and Mental Retardation two years ago. This "Community-based System" model uses a "Dental Coordinator" to help

develop treatment resources and get people who need those resources into care. You saw the importance of this model in Sarah's Story. It has been very successful in improving oral health in the communities where it is being employed, but it depends on a base of funding through California's adult dental Medicaid system. This system has been threatened recently and does not exist in many states.

So the answer to promoting oral health and well being for people who are disabled and elderly lies in several areas:

- We need to build awareness of the importance of oral health and the consequence of dental disease for people with special needs.
- Awareness must be build through education. We need education for dental health, general health, and social service professionals, and caregivers and the general public. Special Care Dentistry is dedicated to building this awareness through education, but we need help.
- We must provide support to professionals and others who are trying to do the right thing. Many dentists who want to help people with disabilities and frail elderly individuals feel that they are met with nothing but barriers and they give up. The same is true for caregivers and general health and social service professionals.
- Finally we can only be successful in providing awareness, education, and support if there is a base of stable funding for "aged, blind, and disabled" people under our state's Medicaid systems.

I urge this committee and others to support inclusion of adult dental benefits in all of our state's Medicaid systems for people who are "aged, blind, and disabled", our most vulnerable citizens.

Thank you for your time.

Sarah's Story

A videotape produced by:
Paul Glassman DDS, MA, MBA and Christine Miller RDH, MHS, MA, Co-Directors
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Special thanks to Karen Toto, Project Manager

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Title:

Sarah's Story

Narrator: Dr. Paul Glassman

"This is Sarah's Story. Fortunately it's a story with a happy ending, but it could have turned out differently. It's a story that illustrates how critical it is for adults who are "aged, blind and disabled" to have basic oral health care coverage under their state's Medicaid system.

Sarah was living in a community residential care facility when this story began. She began to lash out at the other residents of her home. Her caregivers realized that they could no longer guarantee her safety and the safety of other residents of her home. At that point Sarah was admitted to a locked psychiatric facility where the cost runs over $150,000 a year to the State of California."

Nadine Hernandez, Sarah's Mother

"My daughter's disability is she was born with Pierre-Robin syndrome and she has autistic tendencies. Sarah communicates in non-vernal way. She has a small grasp of sign language and she uses hand gestures and moanings and groanings to let you know what her needs are. Last year Sarah had a crisis where she was admitted to a psychiatric facility. She's non vernal so we did not know and she had no way to let us know that she was having dental health problems and she had an infection in her tooth at the time and so it led to her acting out and her behavior became un manageable. And because of that she was sent to an emergency room and from there a resources center to the psychiatric facility and that's how she ended up there and had that crisis.

This behavior for Sarah was unusual. She had been in a home facility for a while where the women there knew pretty well her behavior and when she was acting out she knew what it was and how to deal with Sarah and how to get information from Sarah and what might have been bothering her. But this was so painful for Sarah that the behavior

became ultra large and where none of us, even I, could figure out what was causing Sarah's behavior too become so bizarre. She was throwing herself into walls, she was physically hurting herself. She was just screaming constantly in pain."

Narrator: Dr. Paul Glassman

"Fortunately for Sarah she lives in a state where there is Medicaid coverage that includes adult dental benefits. In addition, the Regional Center in her area uses the services of a "Dental Coordinator" a specially trained dental hygienist who helps people with disabilities get access to dental services and maintain oral health. Christina Macasiet, The Regional Center's dental coordinator was able to identify that Sarah did have dental problems and find a dentist who was able to treat Sarah."

Nadine Hernandez, Sarah's Mother

"They came in, they did the dental work on her, and within 24 hours she was behaving normally or what we would consider normal for her type of disability whereas prior to that she was physically hurting herself, causing harm to others and throwing herself into walls. If she had not intervened and had not found the resources for Sarah's dental health that today Sarah would be a tragedy. Whereas this story ends up being a story of survival because Sarah did survive, because the resources were there were Sarah. That if she had stayed there in that psychiatric facility I'm not sure where Sarah would be today. I know pretty much where I would be.

My experience with the dental coordinator with the Regional Center was exemplary. As a patent I can only say that if those resources are not set in place for children and adults that need these services, then we are at a loss. As a parent, as a guardian of children with disabilities and adults with disabilities, love can only go so far. At that point we need help. We need outside services. We need outside resources and I have to say how grateful I am that Sarah was able to get those resources."

Cristina Macasaet, Dental Coordinator

"For people with disabilities there is an ongoing struggle nationwide with untreated dental disease due to their inability to communicate, perform daily oral care, and the limited access to dental treatment and services. These individuals are more likely to develop severe dental decay and gum disease. They often times have complex medical and psychosocial conditions that may affect dental treatment and care. These individuals are aging and elderly, are babies born and/or diagnosed with some developmental disabilities. Without adult dental services there will be an increase in emergency room visits and hospitalizations. There will be an extreme financial cost to families and ultimately the public health system.

If Sarah did not have any dental benefits she would still be in that locked facility in La Centinas hospital. She would still be suffering from unnecessary dental pain and undiagnosed dental pain. She would still be taking needless medications to control the

aggressive and severe behavior. If she did not have dental benefits she would not be able to be treated for her dental pain and she would not be in a community care home where she is right now."

Narrator: Dr. Paul Glassman

"So, Sarah's story has a happy ending. She is living back in the community Christina is working with her and her caregivers to be sure that she maintains her new dental health.

However, her story illustrates how complicated life can become for someone with a disability who has untreated dental problems and how undiagnosed and untreated dental problems can result in terrible costs to society in dollars and human suffering. We must create funding under Medicaid for all indigent adults who are "aged, blind, and disabled" and support innovative programs to maintain oral health for our most vulnerable citizens."

Credits:

Thank you to Sarah and her family for allowing us to tell her story. We hope it will help others realize the importance of preventive and ongoing oral health care for people with special needs.

The contribution and support of the san Gabrial-Pomona Regional Center, Jodi Lenocker, Cristina Macasaet, Louise Bachman & Elena Ropceanu is greatly appreciated.

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Apple Tree Dental

The Apple Tree Dental Model

Presented to the U.S. Special Committee on Aging

Forum on Ageism in Health Care
September 22, 2003

Overview of the Apple Tree Model

The Apple Tree model for care is based on the idea that people of all ages and physical conditions, even those who require special care, should have equal access to the kinds of dental services that are available in a traditional office setting.

For those patients who have mobility problems or have difficulty with transportation, one obvious solution is to bring the dental office to the patient. However, providing mobile on-site care through the Apple Tree model is much more than setting up a traditional private dental office in a nontraditional setting. For instance, the "non-dental" staff, such as nursing staff and/or teachers, primary care physicians, patient representatives, and third party payers, all have important roles to play in the delivery of dental care to the patient. The Apple Tree model includes not just new equipment, but also new methods of communicating, care planning, record keeping and scheduling in order to bring the best possible care to people with special needs.

This description of the Apple Tree model will include a discussion of the following topics:

1. Why is dental care important for nursing home residents?
2. A new way to deliver care through centralized "base" clinics and "satellite sites"
3. Apple Tree Mobile Dental Offices and the mobile dental team
4. The "Dental Liaison" and interdisciplinary care at nursing homes
5. Information systems and informed consent
6. Personnel and management systems
7. Patient care statistics
8. Replication projects
9. Conclusion

1. Why is dental care important for nursing home residents?

- Oral diseases are cumulative and become more complex over time. The older adult population has high rates of oral diseases, exacerbated by the fact that many elderly adults lose their dental insurance when they retire.
- Oral problems have a negative effect on quality of life. Oral-facial pain and tooth loss can greatly reduce the quality of life and restrict major functions. Problems with the teeth and mouth can affect the ability to eat and communicate. Facial disfigurements from oral diseases can lead to loss of self-esteem, anxiety, and depression. Diet, nutrition, sleep, psychological status, and social interaction are all affected by impaired oral health.
- Dental disease has a significant impact on general health. The oral cavity can be a portal of entry for microbial infections that affect the whole body. Oral diseases give rise to pathogens, which can be blood borne or aspirated into the lungs , bringing about severe, life-threatening consequences. Recent research findings have pointed to possible associations between chronic oral infections and diabetes, heart and lung disease, and stroke.

2. A new way to delivery care through centralized "base clinics" and "satellite sites"

Apple Tree Dental has two programs in Minnesota, one in the Twin Cities, a large metropolitan area, and one in the city of Hawley, located in rural northwestern Minnesota on the border of North Dakota. The Twin Cities and Hawley programs operate out of centralized "base clinics" that provide outpatient services to low-income families and children, persons with disabilities and the frail elderly. These unique clinics have much larger than usual treatment rooms designed to accommodate people who use wheelchairs and cannot transfer into dental chairs. In addition, the clinics are the "home base" for delivery of mobile care to "satellite sites", set up in nursing homes or Head Start centers. The base clinics include office space for support staff and a heated garage where the Apple Tree Mobile Dental Offices and trucks are stored and maintained.

Apple Tree's Mobile Offices are NOT Winnebagos. Winnebago-style dental offices have small treatment spaces that are often inaccessible for patients who have mobility problems or who use wheelchairs. Instead, Apple Tree's Mobile Offices are transported inside and set up on-site, in a way that is fully integrated with the host facility.

3. Apple Tree Mobile Dental Offices and Staff

The Apple Tree Mobile Dental Office provides virtually the same clinical environment and technology that is available in traditional offices. For patients, the equipment provides maximum comfort. For the dental team, it provides optimal ergonomics and many new advanced technologies, such as digital x-rays and plasma arc light curing units. Apple Tree Mobile Dental Offices are transported in a large customized truck, called the Multi-site Delivery Vehicle, or MDV. The Multi-Site Delivery Vehicle holds up to six mobile offices. The MDV driver picks up and delivers the dental equipment during the evening, so that the dental crews do not have "down-time" during the day for moving equipment and can spend all their time with patients.

Apple Tree fulfills the role of Dental Director for each of the nursing homes it serves. An Apple Tree hygienist works with the nursing home's assessment team upon each resident's admission, and provides oral health screenings for every resident. The hygienist provides preventive care, develops daily oral care plans to assure that oral health is maintained, and makes prompt referrals when necessary. Patients who need dental treatment are served by the mobile dental team. This team includes a dentist, a dental assistant, and a "patient coordinator." The dentist and the dental assistant perform the dental services typical of a traditional dental office. The patient coordinator helps transport patients to and from the mobile dental office location. The coordinator is also available to communicate between the dentist and the nursing staff, and to help the dentist and assistant with patient care as needed. Together, the dental team brings the facility a full range of dental services.

The mobile team is sent to specific locations based on the work of Apple Tree's schedulers. Over the past 18 years, they have refined their system, which includes the use of specialized computer software to facilitate planning. Visits are scheduled with sufficient frequency to keep patient care up-to-date while effectively utilizing the time of dental personnel. Large facilities may need weekly visits, while small ones may need a combination of on-site visits and off-site referrals to assure that resources are used cost-effectively.

Schedulers then develop daily lists of patients to be seen at each facility. They use Apple Tree Dental Office Software to track the number of new patients, those undergoing treatment, those due for a recall exam, and those who have urgent dental concerns. They combine this information to make a daily schedule for each dentist. Each dentist serves a consistent set of nursing homes in order to assure continuity of care and to establish stable dentist/patient relationships.

4. The "Dental Liaison" and interdisciplinary care at nursing homes

In order to coordinate care, the Apple Tree model includes the training a "Dental Liaison" from each of its ninety-three facilities. The Dental Liaison is the communications link between Apple Tree and the facility. The most important responsibilities of the Dental Liaison include:

1. Training nursing staff and intake workers on protocols and procedures for routine and emergency care, and assuring that all residents are referred for routine care.
2. Serving as the dental communication link, routing reports of dental problems to the dental team, and conveying information from the dental team back to the facility.
3. Assuring that the dental team receives charts, health status and nursing assessment information, and other assistance needed to provide care.

Nursing and professional staff in the long-term care setting are critical in identifying their residents' oral health needs and connecting them to dental personnel who can address those needs. In this system, nurses play several key roles, such as providing health status updates when necessary, and relaying dental concerns to the Dental Liaison. Following on-site visits, nursing staff are responsible for carrying out postoperative orders and for modifying daily oral care plans as directed. Nurses must also be involved in medical-dental consultations and in the coordination and administration of medications needed to provide dental care. Finally, nurses may need to assist with communication, mental status assessment, resident transfers, and behavior management to enable every resident to obtain needed care.

Other facility staff members are also valuable adjuncts in the provision of appropriate oral health care. Physical therapists can evaluate existing function. Occupational therapists can make recommendations regarding the resident's oral self-care ability. Social workers can provide insights into social, financial, and family issues.

5. Information systems and informed consent

Informed consent is an essential part of the Apple Tree model. Before seeing a patient for an initial exam and prior to carrying out dental treatment, the dentist obtains consent from someone who is capable of fully understanding the plan for treatment, either the patient or a patient representative. Also, in some cases, prior authorization from the insurance carrier is required before treatment can be started.

Since many nursing home patients are unable to make their own treatment decisions, Apple Tree has developed a system that provides a written treatment plan to each patient or their patient representative. The treatment plans use plain language to describe the dental problems, the treatment recommendations, the risks of undergoing the dental procedures, and the problems that can be expected if treatment is delayed or avoided. The plans also include an estimate of the number of visits needed to complete the plan, and the costs involved based on the patient's insurance coverage.

Apple Tree depends on its customized Apple Tree Dental Office Software™ to fulfill unique data collection, scheduling, treatment, consultation and billing functions efficiently and cost-effectively. In order to keep this software continually updated, Apple Tree employs a full-time Director of Information Systems. Apple Tree's record keeping systems have been developed to meet the needs of the nursing home facility and are designed to be incorporated into the facility's existing medical records. The use of terminology appropriate to the nursing staff facilitates communication and follow-up care.

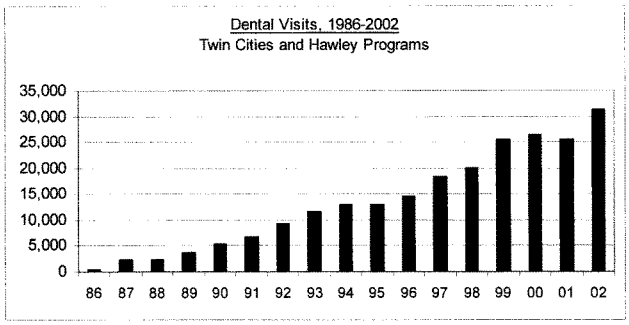
6. Personnel and program management

The Twin Cities program has about fifty employees. The clinical staff includes twelve dentists, three hygienists, thirteen dental assistants, three lab technicians and eight office staff. In northwestern Minnesota, Apple Tree's Hawley program has a staff about twenty, including five dentists, three hygienists, five dental assistants, an office manager, and four office staff.

In order to provide administrative support for its Twin Cities and Hawley programs, Apple Tree's Leadership Team includes a chief executive officer, a director of community dentistry, dental directors, a director of finance, a director of information systems, two development staff, a director of project development, and a director of human resources.

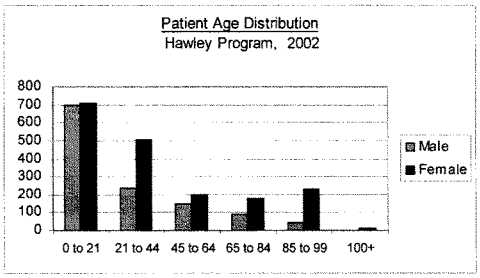
7. Apple Tree's patient care statistics

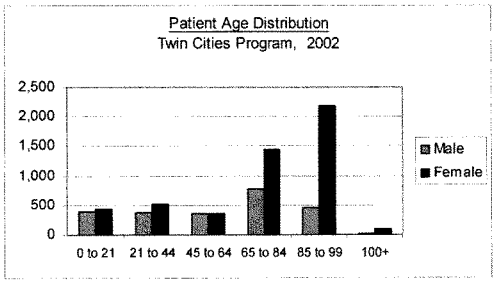
For eighteen years, Apple Tree has brought needed care to vulnerable population groups. In 2002, the total number of dental visits provided by the Twin Cities and Hawley programs was 31,231, as illustrated in the chart. 20,579 of these visits took place in the Twin Cities, and 10,652 dental visits were provided through the Hawley Program.



Whether treatment takes place at one of Apple Tree's base clinics or inside a community satellite facility, all dental services are offered, from check-ups and fillings to oral surgery. Apple provides comprehensive ongoing care, not just emergency care or screenings.

The Hawley Program serves the Red River region of Minnesota and North Dakota including the counties of Clay, Cass, Polk, Norman, Mahnomen, and Becker, with additional service to Clearwater, Hubbard, Otter Tail, Pennington, Red Lake, Wadena, and Wilkin counties.





The Twin Cities Program serves the greater Minneapolis/St. Paul area including Hennepin, Anoka, Washington, Ramsey, Carver, Dakota, Scott, Wright, Sherburne, Isanti, and Chisago counties.
In 2002, 4,860 patients were between age 65 and 99.
105 patients were 100 years old or older!

8. Program replication

Apple Tree has helped create two successful replication projects in North Carolina, and one in Louisiana. *Carolinas Mobile Dentistry* was the first such project, started in 1997 under the leadership of Dr. Ford Grant to augment the Carolinas Medical Center's Dental General Practice Residency Program. *Access Dentistry,* in Greensboro, North Carolina, began in 2000 to serve both nursing homes and group homes for the developmentally disabled. Dr. Bill Milner, the project's director, expects *Access Dentistry* to grown statewide. *Operation Smile*, in Sicily Island, Louisiana, is a mobile dental outreach component of the Catahoula Parish Medical Center. This project, started in 2001, brings dental care to Head Start centers in the area, with plans for the future to expand care to nursing homes and schools.

9. Conclusion:

Apple Tree Dental has proven that, through public/private partnerships, it is not only possible, but practical and affordable to provide the on-site dental care that nursing home residents so desperately need.

Apple Tree programs have improved the lives thousands of frail elderly people in Minnesota, North Dakota, North Carolina, and Louisiana. If Medicaid benefits to this population group were cut, as they almost were last year, it would be devastating, not only to Apple Tree, but more importantly to our frail elderly patients who would have nowhere else to turn.

The frail elderly are just as dependent as children when it comes to health care. Justice compels us to end the willful neglect of our elders. Together, we must assure that frail elderly adults everywhere in America receive the dental benefits they need and deserve.

Testimony of
Kim Volk
President & CEO
Delta Dental Plans Association
Submitted to
U.S. Senate Special Committee on Aging
October 3, 2003

Chairman Craig, Senator Breaux and distinguished members of the Committee-

Thank you for the opportunity to submit this statement in connection with the Committee's September 22, 2003 forum, "Ageism in Health Care: Are Our Nation's Seniors Receiving Proper Oral Health Care?" The Delta Dental Plans Association (DDPA) applauds your efforts to call national attention to an issue that has been long overlooked by many.

In the way of background, Delta Dental is the nation's largest, most experienced dental benefits carrier. Since 1954, Delta Dental has worked to improve oral health in the U.S. by emphasizing preventive care, and making dental coverage affordable to a wide variety of employers and groups. A nationwide system of dental health service plans, Delta Dental offers employers, large and small, custom programs and reporting systems that provide employees with quality, cost-effective dental benefit programs and services. Our member Plans serve nearly one-quarter of the estimated 170 million Americans with dental insurance, providing dental coverage to over 42 million people in nearly 75,000 groups across the nation. Delta Dental's panel of dentists for its fee-for-service product is the country's most extensive. Delta contracts with over 108,000 dentists – or almost three out of every four U.S. dentists – in 135,492 locations.

Mr. Chairman, on the basis of his study of the world's great civilizations, the historian Toynbee concluded that a society's quality and durability can best be measured "by the respect and care given its elderly citizens." In that regard, the true measure of our society will certainly be tested over the coming decades.

Just as the baby boom generation once flooded maternity wards and classrooms, so too will it strain the nation's health care system. Today, an estimated 35 million people are age 65 and older. By 2030, twice as many Americans—about 1 in 5—will have passed their 65th birthday. Because of remarkable scientific advances and an array of modern drugs, Americans are generally living longer, more productive lives. In 1900, average life expectancy at birth was 49 years. In 2000, life expectancy at birth stood at 77 years. But those added years of life are presenting new challenges, and no where is that more evident than when it comes to the oral health needs of the elderly.

It is well known that the incidence of dental decay has decreased over the last 50 years. Today, in fact, many children reach adulthood without ever having a cavity. But dental disease rates actually begin to *increase* after age 45, and nearly double by age 65. So as more Americans approach mid-life with the expectation of keeping all or most of their

own teeth, oral health and dental care become far more significant factors in their health status and quality of life.

As individuals age, gum tissues shrink, exposing the softer, more decay-prone surfaces of the teeth; physical complications such as arthritis can hamper daily brushing and flossing; and prescription medicines can lead to increased risk of dental problems. Periodontal disease is the most common threat to oral health in older adults, affecting 27 percent of the over-65 population. But this disorder, which is manifested by the loss of connective tissue and bone that supports teeth, is not only one of the most common causes of pain, discomfort and tooth loss. It is often linked to a host of other serious health problems.

- Periodontal infections, for example, may play a significant role in causing lesions in the heart, brain and extremities, leading to heart attacks, stroke and respiratory disease.

- Osteoporosis, a disease that affects 20 million people, most of whom are women, has been linked to the bone loss that occurs with periodontal disease.

- Nearly one-third of people with diabetes suffer from severe periodontal disease.

- Hormonal fluctuations during menopause can trigger physical changes that make oral tissue more vulnerable to inflammation and gum disease.

Clearly, good oral and dental health care must play a prominent role in the health and well-being of an aging society. Poor oral health and untreated dental problems can lead to chronic pain, disability, disfigurement, inadequate nutrition and a lesser quality of life. The problem is especially acute among elderly minorities and those residing in rural communities and nursing homes. Conversely, regular check-ups and preventive maintenance can prevent or lessen the need for more extensive and more expensive treatments later.

Recommendations

Access to primary preventive and early intervention dental services must be improved for older Americans, and barriers to the dental care system should be removed. To those ends Delta Dental believes that with proper coordination and a sufficient investment of resources, society has the ability to address the oral health needs of older Americans. As the Committee continues to explore ways to do that, Delta Dental urges you to consider the following-

Preserve existing dental insurance coverage and provide incentives for reaching the uninsured. - According to the Surgeon General's report, *Oral Health in America*, 108 million Americans lack dental insurance coverage, nearly three times the number who lack medical insurance. It is noteworthy that those who have dental insurance are more than *twice* as likely to visit a dentist's office than those who do not. As a result, they are

more likely to stave off serious oral health problems or avoid more expensive, time-consuming treatments later.

- Make the cost of purchasing dental insurance an eligible expenditure for any tax credit or tax deduction enacted adopted by Congress.

- Ensure that any new federal laws or regulatory requirements take into account the distinction between medical and dental insurance, particularly the fact that added administrative requirements will disproportionately affect dental insurance costs.

- Take steps to preserve the availability of employer-sponsored health benefit plans for retirees.

Restore the importance of oral health in public assistance programs. - Medicaid and the SCHIP program exist to help low-income individuals receive quality care, yet access to, and utilization of dental services is very limited. While the federal government contributes approximately 48 percent towards the cost of all medical care, less than 5 percent is allocated for dental care.

- Provide resources to establish or expand oral health services at federally-funded community health centers.

- Provide states with an enhanced federal match for agreeing to cover full adult dental benefits under the Medicaid program

- Create incentives for states to pay market-based reimbursement for dental services under Medicaid.

- Enforce existing federal rules for assessing the extent and quality of daily oral care provided to nursing home residents.

Incentivise treatment for special needs patients. -

- Provide an enhanced federal Medicaid match to skilled nursing facilities that retain dentists who provide direct in-facility care; provide enhanced outpatient hospital facility payments for dentists to treat medically-compromised seniors in an appropriate setting.

- Provide funding for dental hygienists in skilled nursing facilities to encourage screening, hygiene and referral to a licensed dentist for treatment.

Train tomorrow's dentists. - Surveys indicate that dentists often feel ill-equipped to meet the special needs of older and some otherwise compromised patients. Only 27 of today's dental schools require that students have a geriatric clinical experience actually treating elderly patients.

- Support incentive grants to dental schools for specialized geriatric dentistry training programs, including training for special needs patients in skilled nursing facilities.

Support increased research at the National Institute of Dental and Craniofacial Research, the Agency for Healthcare Research and Quality, and the Centers for Disease Control and Prevention. - Society as a whole has benefited from past investments in research, much of which have been supported by NIDCR, AHRQ and CDC. Scientists now are exploring connections between periodontal and systemic diseases, and identifying genes that may help in developing therapeutic approaches to many oral diseases.

- Support continued research in risk assessment for oral disease, and encourage the development of practice-based networks to further refine these tools.

- Encourage NIDCR and other federal agencies to support research efforts to identify the most appropriate methods of addressing the unique oral health needs of an aging population, with special emphasis on NIDCR's Centers for Research to Reduce Disparities.

- Support research on the use of saliva as a diagnostic tool, as well as biomimetic and tissue engineering research that may lead to the replacement of lost tooth structure with human tissue.

Encourage greater public awareness of the importance of oral health and regular dental care.

- Direct the U.S. Surgeon General's office, NIDCR and the National Institute on Aging to work collaboratively with other stakeholders, including the dental insurance community, to develop and implement a nationwide public awareness program to educate health care professionals, hospital and nursing facility personnel, the media and the general public.

Thank you for the opportunity to submit this testimony. Delta Dental stands ready to assist the Committee in any way possible.

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