

**President Proposes Outline for Health Care Reform**

On February 22, President **Barack Obama** released an 11-page summary of his health care reform proposal. He also sent a letter to congressional leaders on March 2 with recommendations that the White House says will attempt to “bridge the gap between the House and Senate bills.” H.R. 3590, as amended in the Senate, is the basis for the President’s plan with a set of changes that “reflect policies from the House-passed bill and the President’s priorities.”

On January 8, ADEA President **Ronald J. Hunt** and ADEA Executive Director **Richard W. Valachovic** sent letters to Senate Majority Leader **Harry Reid** and Speaker of the House of Representatives **Nancy Pelosi** informing them of a number of provisions in the House and Senate reform bills for which ADEA was advocating. On February 19, Drs. Hunt and Valachovic reiterated these preferred provisions in a letter to President Obama.

As reported in the January 11, 2010, edition of the **Washington Update** (Vol. 8, No. 1), ADEA supports several provisions in the Senate bill that are of significance to academic dentistry and oral health, namely:

- 1. A provision that would create a new dental section and funding line for training in general, pediatric, and public health dentistry in the Title VII Health Professions Programs.** This provision would establish a separate dental section under Title VII, Part C of the Public Health Services Act that increases eligibility for new grant programs to train dental and allied dental health professionals. ADEA recommends a separate funding line of \$30 million in FY 2010 for the dental section under Title VII and such sums as necessary thereafter.
- 2. A provision that would protect the Children’s Health Insurance Program (CHIP).** The House bill ends CHIP funding in 2013 and folds it into the health insurance exchange. The Senate bill extends the CHIP program through 2015. This change would provide more time to test the new health insurance system to ensure that it can safely and effectively provide the best health coverage for our nation’s children.
- 3. A provision that would allow Indian tribes and tribal organizations in a state (other than Alaska) to employ dental health aide therapists when authorized under state law.** The provision would allow a dental health therapist or mid-level dental health provider to provide oral health services when a state authorizes such services in accord with state law.
- 4. A provision that would establish an oral health prevention program.** The provision would direct the Centers for Disease Control and Prevention (CDC) to implement a national prevention program and award demonstration grants to community providers for research into the management of dental disease. The provision also provides funds to all 50 states, territories, and tribal units of government to develop oral health leadership, enhance oral health data systems, improve the delivery of oral health, and implement dental sealants, water fluoridation, and other preventive programs.
- 5. A provision that would review the adequacy and effectiveness of payments for dental services with regard to achieving Medicaid and CHIP program goals through a new Medicaid and CHIP Payment and Access Commission (MACPAC).** The provision would authorize the Commission to review payments for dental services and establish a process for updating payments to dental health professionals. The Commission must consider both federal and state payment policies and their effect on access to and quality of care and determine whether they enable (or hinder) enrollees’ ability to obtain services. It must also consider how payments affect provider supply and

how they affect providers who serve a disproportionate share of low-income and vulnerable populations. The provision reaffirms that dentists shall be members of the Commission.

The ADEA letter to the President also identified and expressed strong support for several provisions in the House-passed health care reform bill, namely:

**1. A provision that guarantees oral health insurance coverage for children.** The provision would designate that dental benefits for children are part of the essential benefits package, would define covered services to include well-baby and child oral health care for children up to 21 years of age, and would include recommended preventive services.

**2. A provision that would make the didactic activities of medical and dental residents count toward Graduate Medical Education funding.** The provision would clarify that the time residents (medical and dental) spend in didactic (scholarly) activities counts toward IME and D-GME full-time equivalency when it occurs in hospital settings and toward D-GME when it occurs in non-hospital settings. The provision would apply to cost reports beginning on or after July 1, 2008.

**3. A provision that would require oral health expertise on the Health Benefits Advisory Committee.** The Committee would set minimum requirements for health plans and establish essential health benefits. The provision would require that membership on the Committee must include “experts in oral health” who will inform decisions on technically difficult and complex matters concerning health care coverage and benefit design.

**4. A provision that would require a study to determine the need for adult dental coverage.** The provision would direct the Department of Health and Human Services (HHS) to study and report back to Congress within one year on the need for and cost of providing guaranteed adult dental coverage as part of an essential health benefits package.

ADEA recently sent correspondence to senior White House health care reform staff emphasizing the importance of including these House-passed provisions in the President’s plan. Since the Senate proposal is the basis for the President’s plan, we are encouraged that the Senate provisions outlined above will be included. However, staff of the ADEA Center for Public Policy and Advocacy (ADEA CPPA) are intent on making certain that the House-passed provisions, especially the GME provision, are part of the President’s proposal.

### **President Speaks Out on Oral Health**

In response to a question during a Presidential Town Hall meeting in Henderson, Nevada, on February 19, 2010, President **Barack Obama** made the following remarks about the importance of oral health:

“It turns out—this is serious—that dental hygiene is actually very important for keeping your heart healthy. It turns out that heart disease can be triggered when you’ve got gum disease. So everybody floss...that’s my first [comment]...am I right? You’ve got to floss. **It is my hope that we can include dental care in the various proposals that we are putting forward. Dental and vision care are very important.** (Emphasis added)

Now I’ll tell you that some folks will say we can’t afford it. Some states in their Medicaid program cover dental, some states don’t. At minimum, I think it is very important that we’ve got dental care for our kids. Because what happens is that if we can keep our children’s teeth healthy, then usually that means they’ve got healthy teeth as adults...and if not...oftentimes that actually distracts them and prevents them from learning because, you know, both dental and eye care—a lot of kids end up being distracted, they can’t read the blackboard, they’ve got a cavity that’s been untreated, it’s a huge problem. **So, I would like to have dental care covered, I’ll tell you that some folks are going say we can’t afford it. At minimum I would like to see that our children have the care that they need.**” (Emphasis added)

## **President Introduces His Budget for FY 2011**

The President has released his FY 2011 budget, which provides a description of the administration's fiscal policies and major budgetary initiatives. In the \$3.8 trillion budget, the President called for a partial three-year freeze on non-discretionary spending. The freeze, which the administration estimates would save \$250 billion, would not apply to the Departments of Defense, Homeland Security, and Veterans Affairs, along with select international and domestic programs, including many K-12 and higher education programs.

The President's budget requested:

- Approximately \$509 million for the Title VII Health Professions Programs, an \$11 million (2.2 percent) increase over FY 2010 enacted levels. The increase is designated for the Title VII workforce information and analysis program, which is proposed at \$8.8 million, a 210 percent increase over FY 2010.
- Level funding for all other Title VII and Title VIII programs
- \$15 million for general and pediatric dental residency programs
- \$17.5 million for the Dental Health Improvement Act
- \$169 million for the National Health Service Corps (NHSC), a \$27 million (19 percent) increase over FY 2010
- \$78 million for the Office of the National Coordinator (ONC) for Health Information Technology (HIT), a \$17 million (40.4 percent) increase over FY 2010
- \$32 million for the Agency for Health Research and Quality (AHRQ) for the use of HIT to enhance patient safety
- \$1 million in the Office of the Assistant Secretary for Planning and Evaluation for evaluation of electronic health record (EHR) adoption

An increase of \$40 million is budgeted for care and treatment through the Ryan White HIV/AIDS Program. The funding for Ryan White Part F dental programs increases by \$1.8 million. In addition, the President's budget also includes a \$2.6 million increase for the Ryan White AIDS Education and Training Centers (AETC). The AETCs are an important part of ensuring the Ryan White Program provides the highest quality of care to people living with HIV and AIDS.

Despite the spending freeze, the President proposed more funding for research. The National Institutes of Health would receive a \$1 billion increase in 2011, to \$32.3 billion. The National Institute of Dental Craniofacial Research received a modest 2.5% increase of \$423.5 million.

Similar to the FY 2010 budget, the President's budget for FY 2011 proposes to eliminate the Federal Family Education Loan (FFEL) program and originate all new Stafford loans under the Direct Loan program beginning July 1, 2011. The budget also proposes to increase to \$6 billion the total annual loan amounts available under the Perkins Loan program, from its current \$1 billion. The budget documents are available at <http://www.gpoaccess.gov/usbudget/fy11/index.html#appendix>.

## **IOM Oral Health Committees Established**

The Health Resources and Services Administration has awarded \$2.4 million to the National Academy of Sciences, the Institute of Medicine (IOM) to conduct a wide-ranging study of oral health care and to suggest ways it can be improved. The National Academy of Sciences, the Institute of Medicine's (IOM) Board on

Children, Youth and Families, and the Board on Health Care Services established two 15-member committees of experts in oral health and other health-related services to:

- Examine the oral health system of care in the U.S. as it currently exists
- Explore its strengths, weaknesses, and future challenges
- Describe a desired vision for the oral health care system
- Recommend strategies to achieve that vision

The Committee on Oral Health Access to Services held its first meeting March 4-5, 2010. The Oral Health Initiative Committee will hold its first meeting March 31 - April 1, 2010. Following are the committee rosters:

#### **Oral Health Access to Services Committee**

**Dr. Frederick P. Rivara - Chair**  
**University of Washington School of Medicine**

**Ms. Jane Perkins**  
**National Health Law Program**

**Dr. Paul Erwin**  
**University of Tennessee, Knoxville**

**Ms. Margaret Potter**  
**University of Pittsburgh**

**Dr. Caswell A. Evans, Jr.**  
**University of Illinois at Chicago**

**Dr. Renee Samelson**  
**Albany Medical College**

**Dr. Theodore G. Ganiats**  
**University of California, San Diego**

**Dr. Phyllis W. Sharps**  
**Johns Hopkins University School of Nursing**

**Ms. Shelly Gehshan**  
**Pew Center on the States**

**Dr. Linda H. Southward**  
**Mississippi State University**

**Ms. Kathy Geurink**  
**University of Texas Health Science Center at San Antonio**

**Dr. Maria Rosa Watson**  
**Primary Care Coalition of Montgomery County, Inc.**

**Dr. Paul Glassman**  
**University of the Pacific Arthur A. Dugoni School of Dentistry**

**Dr. Barbara L. Wolfe**  
**University of Wisconsin-Madison**

**Dr. David Krol**  
**Robert Wood Johnson Foundation**

#### **Oral Health Initiative Committee**

**Dr. Richard D. Krugman - Chair**  
**University of Colorado Denver**

**Professor Mary C. George**  
**University of North Carolina at Chapel Hill**

**Dr. Claude Earl Fox**  
**University of Miami**

**Dr. Alice Horowitz**  
**University of Maryland, College Park**

**Dr. Terry T. Fulmer**  
**New York University**

**Dr. Elizabeth A. Mertz**  
**University of California, San Francisco**

**Dr. Vanessa Northington Gamble**  
**George Washington University**

**Dr. Matthew J. Neidell**  
**Columbia University, Mailman School of Public Health**

**Dr. Paul Gates**  
**Bronx-Lebanon Hospital Center**

**Ms. Sara Rosenbaum**  
**George Washington University. School of**  
**Public Health and Health Services**

**Dr. Harold C. Slavkin**  
**University of Southern California**

**Dr. Clemencia Vargas**  
**University of Maryland at Baltimore**

**Dr. Michael W. Painter**  
**Robert Wood Johnson Foundation**  
**Dr. Robert Weyant**  
**University of Pittsburgh**

**Dr. Jose F. Cordero**  
**University of Puerto Rico - Rio Piedras**

The IOM's final report will review elements of a national oral health initiative; propose ways the HHS Secretary, HRSA Administrator, and other HHS agencies can implement such an initiative; and recommend a strategy to improve the public's awareness of existing HHS oral health activities and the services available.

### **ADEA Comments on HRSA Draft Report**

In January, the Advisory Committee on Training in Primary Care Medicine and Dentistry released a draft of its 8<sup>th</sup> annual report to the Secretary of Health and Human Services (HHS), entitled "The Redesign of Primary Care with Implications for Training." The report, which provides recommendations on how to increase the number of primary care practitioners, stated that there is a need to: "1) develop education initiatives to fill the gaps in the primary care workforce rapidly; 2) support system changes that promote efficient inter-professional models of care in which individuals from a variety of areas of expertise collaborate to meet patient health care needs; and 3) align financial incentives to support primary care to schedule the desired access, quality, and efficiency outcomes."

ADEA submitted comments in response to the report highlighting aspects of dental education and training that are different from that of physicians. For instance, medical schools are eligible for grants to fund academic administrative units (AAUs) for which dental schools are not eligible. ADEA also pointed out that most dentists go into general dentistry and are primary care practitioners, unlike medicine, where a majority of physicians choose to specialize. In addition to these different characteristics of medical and dental education, ADEA also commented on each of the recommendations made by the Committee. (See pages 10-16.)

The Committee produces a yearly report, as mandated by the Health Professions Education Partnerships Act of 1998. The role of the Committee is to provide advice and recommendations to the Secretary of HHS on public policy concerning Title VII, section 747, which is the funding mechanism for training programs in primary care medicine and dentistry. In particular, the comments focus on matters concerning program development in the Health Resources and Services Administration (HRSA) Bureau of Health Professions general dentistry, pediatric dentistry, family medicine, general internal medicine, general pediatrics, and physician assistant programs. ADEA will provide a copy of the final report when it is released.

### **ADEA Joins Coalition for Health Funding on Budget Letter**

March marks the month that Congress usually votes on a "Budget Resolution," which provides the aggregate number that the Appropriations Committee has to spend on the funding bills for the next fiscal year. As the House and Senate Budget Committees begin to deliberate on needed amounts, ADEA (along with a number of other organizations, such as the American Public Health Association and the Friends of the National Health Service Corps) wrote to Congress. The letter highlighted the need for funding for the education and training in health professions, biomedical and behavioral research, health services research, and public health programs, among other programs. All of these programs fall under "Function 550" in the budget. The aggregate amount that the coalition requested for Fiscal Year 2011 is \$67.1 billion, which is \$9.3 billion more than Fiscal Year 2010.

### **ADEA Supports Proposal to Expand IBR**

President **Barack Obama's** fiscal year 2011 budget included an expansion of the Income-Based Repayment (IBR) program. Currently, the program bases student loan payments on income levels, and the payments are 15 percent of the borrower's net income above 150 percent of the federal poverty level. Under IBR, the borrower would be forgiven debt after 25 years of payment. The President's budget requests that the IBR payments be lowered to 10 percent of the borrower income above 150 percent of the federal poverty level, and that the debt is forgiven after 20 years of payment.

ADEA joined with a number of other organizations including the American Council on Education (ACE) and the American Indian Higher Education Consortium in sending a letter to **Vice President Joe Biden** in support of this expansion.

### **Dental Briefing on Capitol Hill**

The American Dental Education Association sponsored a briefing for congressional staff on children's oral health and access to dental services on Capitol Hill in February. Speakers highlighted National Children's Health Month, oral health provisions in the Senate and House-passed health care reform proposals, and advances in oral health since the tragic death in February 2007 of **Deamonte Driver** from complications of untreated tooth decay.

Dr. **Gregory Stoute**, ADEA/Sunstar Americas, Inc./Harry W. Bruce, Jr. Legislative Fellow, served as moderator for the briefing and outlined actions to prevent childhood dental problems and improve children's access to dental care. Dr. **Frank Catalanotto**, Chair of the Clinical Sciences Department at the University of Florida College of Dentistry and a member of the ADEA Legislative Advisory Committee, provided a comprehensive overview of the oral health services being provided by the University of Florida dental clinics throughout the state to vulnerable populations. Dr. **Caswell Evans**, Associate Dean for Prevention and Public Health Sciences at the University of Illinois in Chicago and a member of the ADEA Legislative Advisory Committee, emphasized the impact the new dental public health curriculum at the university has had in building a dental health workforce to increase access to care. Dr. **Harry Goodman**, Director of Oral Health in the Maryland Department of Health and Mental Hygiene, discussed Maryland's oral health access reforms and the success of increasing provider participation in the state's Medicaid program.

All speakers agreed that the passage of CHIP was an excellent first step in addressing the critical importance of oral health to children's welfare and the need to eliminate barriers to dental care. However, they stated that more work is necessary to eliminate oral health disparities and improve access to quality oral health services for underserved and underinsured populations.

### **IRS to Refund FICA Taxes to Residents for Tax Periods Before April 2005**

On March 2, 2010, the Internal Revenue Service (IRS) announced an administrative determination that medical residents are exempted from the Federal Insurance Contributions Act (FICA) tax for periods before April 1, 2005, when regulations were clarified. Before these regulations were published, the IRS maintained that residents were employees and thus had to pay the taxes. There have been a number of lawsuits brought against the IRS concerning these funds, which speculators have pointed to as a reason for the new determination. The IRS will begin contacting hospitals, universities, and medical residents who filed FICA (Social Security and Medicare tax) refund claims.

### **Upcoming Meetings and Conferences**

- **April 13-17, 2010, American Academy of Oral Medicine** will host its **64<sup>th</sup> Annual Meeting** with the theme "Oral Medicine and Immunity" at the Hyatt Regency Tamaya Resort and Spa in Santa Ana Pueblo, New Mexico. Early registration closes March 26, 2010. Please visit [www.aaom.com/cde.cfm?event=225266](http://www.aaom.com/cde.cfm?event=225266) for registration information.

- **April 26-28, 2010, The National Oral Health Conference** occurs at The Hilton at the Ballpark in downtown St. Louis, Missouri. Please visit <http://www.nationaloralhealthconference.com> for available information on the conference or call the NOHC office at 217-529-6503 with any questions.
- **April 29-May 2, 2010, American Academy of Orofacial Pain** holds its **34<sup>th</sup> Scientific Meeting** at the newly renovated Disney World Contemporary Conference Center in Orlando, Florida. For meeting and registration information, please visit [www.aaop.org/index.asp?Type=B\\_EV&SEC={A4704A5A-11E9-4719-B90A-5D4459C7211B}&DE={6F483C67-9E1B-4AE0-96B3-CABD446301C8}](http://www.aaop.org/index.asp?Type=B_EV&SEC={A4704A5A-11E9-4719-B90A-5D4459C7211B}&DE={6F483C67-9E1B-4AE0-96B3-CABD446301C8}).
- **September 26-29, 2010, American Academy of Otolaryngology** holds its **2010 AAO-HNSF Annual Meeting and OTO Expo** at the Boston Convention and Exhibition Center, Boston, Massachusetts, expecting to draw almost 9,000 attendees and 300 exhibitors. Please see [www.entnet.org/annual\\_meeting](http://www.entnet.org/annual_meeting) for more meeting information.

### Funding Opportunities

[www.GRANTS.gov](http://www.GRANTS.gov)

You must use [www.GRANTS.gov](http://www.GRANTS.gov) to apply for a federal grant. The registration process can take up to one month. Assistance is available from [www.Grants.gov](http://www.Grants.gov) help desk at [support@grants.gov](mailto:support@grants.gov) or 800-518-4726. To successfully register, it is necessary to do all of the following:

- Obtain an organizational Data Universal Number System (DUNS) number
- Register the organization with Central Contractor Registry (CCR)
- Identify the organization's E-Business Point of Contact (POC)
- Confirm the organization's CCR "Marketing Partner ID Number (M-PIN)" password
- Register an Authorized Organization Representative (AOR)

### Health Resources and Services Administration

- **ARRA -Training in Primary Care Medicine and Dentistry: Residency Training Gen & Pediatric Den, (HRSA-10-073)**. The funds for these grants, of which applications are due by March 24, 2010, were appropriated by both the American Recovery and Reinvestment Act of 2009 (ARRA) and FY 2010 Appropriations bill. No other grant notices for this program will be made for Fiscal Year 2010. For more information, please visit <https://grants.hrsa.gov/webExternal/SFO.asp?ID=198280D6-CFED-4EA5-AE7D-9FEB2EF1D47C>.
- **ARRA - Equipment to Enhance Training for Health Professionals- Residency Training in Dental Public Health, (HRSA-10-176)**. This funding opportunity is for equipment that supports the activities and the goals of the Residency Training in Dental Public Health (DPH) program. Applications are due on March 26, 2010. For more information, please visit <https://grants.hrsa.gov/webExternal/SFO.asp?ID=250704E8-05BE-4BD0-B72D-D60A109B3CFF>.
- **ARRA - Equipment to Enhance Training for Health Professionals- Centers of Excellence Program, (HRSA-10-174)**. Funding is for equipment that supports the goals of the Centers of Excellence program. Applications are due March 26, 2010. <https://grants.hrsa.gov/webExternal/SFO.asp?ID=9C7EA13C-B57B-4F95-A57B-A86A2E62CE05>.

- **ARRA - Equipment to Enhance Training for Health Professionals- Training in Primary Care Medicine and Dentistry- Residency Training in General and Pediatric Dentistry**, (HRSA-10-191). Funding is for equipment for general and pediatric residency training programs. Applications are due March 26, 2010. For more information please visit <https://grants.hrsa.gov/webExternal/SFO.asp?ID=47E6CE50-A483-46F7-9CD8-825BA2E0C2C6>.
- **ARRA - Equipment to Enhance Training for Health Professionals- Grants to States to Support Oral Health Workforce Activities**, (HRSA-10-183). Funding is for equipment that supports activities and the goals of the Grants to States to Support Oral Health Workforce Activities program. Applications are due March 26, 2010. For more information, go to <https://grants.hrsa.gov/webExternal/SFO.asp?ID=19F93202-8F91-479E-89D3-368651C5E601>.
- **Grants to States to Support Oral Health Workforce Activities**, (HRSA-10-070). The announcement calls for applications for the Grants to States to Support Oral Health Workforce Activities Program. Designated state oral health programs and government-approved state government entities are eligible for these grants, which are meant to assist states on improving the accessibility of the oral health workforce for underserved geographic areas and populations. Applications are due April 12, 2010. For more information, please go to <https://grants.hrsa.gov/webExternal/SFO.asp?ID=C4135ADF-11A0-44D6-888E-8211D3352E56>.

#### **National Institutes of Health**

- **Collaborative Research on the Transition From Acute to Chronic Pain: New Models and Measures in Clinical and Preclinical Pain Research (R01)**, (RFA-DE-11-001), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-DE-11-001.html>
- **Strategic Partnering to Evaluate Cancer Signatures [SPECS II] (U01)**, (PAR-10-126), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PAR-10-126.html>
- **Recovery Act Limited Competition: The NIH Directors ARRA Funded Pathfinder Award to Promote Diversity in the Scientific Workforce (DP4)**, (RFA-OD-10-013), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-OD-10-013.html>
- **MARC Undergraduate Student Training in Academic Research (U-STAR) National Research Service Award (NRSA) Institutional Research Training Grant (T34)**, (PAR-10-119), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PAR-10-119.html>
- **Collaborative Research on the Transition From Acute to Chronic Pain: New Models and Measures in Clinical and Preclinical Pain Research (R01)**, (RFA-DE-11-001), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-DE-11-001.html>
- **Partnerships for Biodefense (R01)**, (RFA-AI-10-003), National Institutes of Health <http://grants.nih.gov/grants/guide/rfa-files/RFA-AI-10-003.html>
- **A Centralized Protein Sequence and Function Resource (U41)**, (RFA-HG-10-004), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-HG-10-004.html>
- **Partnerships for Biodefense (R01)**, (RFA-AI-10-003), National Institutes of Health and National Institute of Allergy and Infectious Diseases, <http://grants.nih.gov/grants/guide/rfa-files/RFA-AI-10-003.html>
- **Ruth L. Kirschstein National Research Service Awards for Individual Predoctoral Fellowships to Promote Diversity in Health-Related Research (Parent F31 - Diversity)**, (PA-10-109), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PA-10-109.html>

- **Ruth L. Kirschstein National Research Service Awards for Individual Predoctoral Fellows (Parent F31)**, (PA-10-108), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PA-10-108.html>
- **Ruth L. Kirschstein National Research Service Awards (NRSA) for Individual Senior Fellows (Parent F33)**, (PA-10-111), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PA-10-111.html>
- **Ruth L. Kirschstein National Research Service Awards for Individual Predoctoral MD/PhD and Other Dual Doctoral Degree Fellows (Parent F30)**, (PA-10-107), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PA-10-107.html>
- **Chronic Co-Morbid Conditions in HIV+ U.S. Adults on Highly-Effective Anti-Retroviral Therapy (R01)**, (RFA-NR-10-001), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-NR-10-001.html>
- **Chronic Co-Morbid Conditions in HIV+ U.S. Adults on Highly-Effective Anti-Retroviral Therapy (R21)**, (RFA-NR-10-002), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-NR-10-002.html>
- **Centers of Research Translation (P50)**, (RFA-AR-11-002), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-AR-11-002.html>
- **Scientific Meetings for Creating Interdisciplinary Research Teams (R13)**, (PA-10-1060), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PA-10-106.html>

#### Items of Interest

- The Health Resources and Services Administration (HRSA) is recruiting **Dental Junior Service Fellows** and **Dental Staff Service Fellows** to address oral health infrastructure, delivery, and systems of care. Deadline to submit applications is March 29, 2010. For more information, go to <http://www.hrsa.gov/about/jobs.htm>.

#### Quotable

“They know enough who know how to learn.”

**Henry Adams**

The *ADEA Washington Update* is published by the ADEA Center for Public Policy and Advocacy (ADEA CPPA) monthly when Congress is in session. Its purpose is to keep ADEA members abreast of federal issues and events of interest to the academic dental and research communities.

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## ADEA Issue Brief #10

### ADEA Comments on 8<sup>th</sup> Annual HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry

February 12, 2010

Dr. Jerilyn Glass  
HRSA Advisory Committee on Training in  
Primary Care Medicine and Dentistry  
5600 Fishers Lane, Room 9A-27  
Rockville, MD 20857

Dear Dr. Glass:

On behalf of the American Dental Education Association (ADEA)<sup>i</sup>, we are pleased to submit the following comments regarding the report by the HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) entitled *The Redesign of Primary Care with Implications for Training*.

Before we address the ACTPCMD's ten specific recommendations, we want to highlight some of the factors influencing primary care dental education that are substantially different from primary care medical education and overlooked in the ACTPCMD report. To some degree, this may help to explain why the focus of this report is, in our opinion, primarily on medicine, with a dental perspective largely absent. Of the 79 citations in the report, only three are dental-specific. We encourage ACTPCMD members to better integrate an understanding of primary care dentistry into this and future reports.

#### PRIMARY CARE MEDICINE AND DENTISTRY: DISTINCTIONS

***The environment of primary care medicine is different than dentistry.*** Medicine is experiencing a shortage of primary care providers primarily because medical students are choosing careers in medical specialties. The opposite is true for dentistry. While primary care dentistry is experiencing shortages in the United States, it is not because dental students are choosing careers in advanced dental specialties. A majority (89 percent) of dentists choose to become general practitioners, while only one in five (21 percent) choose careers in dental specialties.<sup>ii</sup>

***Licensure differences influence the dental education model.*** Another important difference between medicine and dentistry concerns postgraduate education. While completion of a postdoctoral residency is required to become licensed in the practice of medicine, it is not a requirement for licensure to practice dentistry in most states.<sup>iii</sup> This means that dental students must, upon graduation, possess all the knowledge and clinical skills necessary to provide comprehensive care to patients. The majority of dental school graduates move immediately into general dentistry practice. Only 39.6 percent of seniors surveyed in 2008 planned to enter an advanced education residency.<sup>iv</sup>

***Dental education lacks equal access to important federal funding sources available to medical education.*** Since medical residency positions are based in hospitals, they receive significant public financial support, primarily through Medicare Graduate Medical Education (GME) funding. Only some postdoctoral dental residency programs qualify for Medicare GME funding. Academic dental institutions (ADIs) also do not have access to other significant Title VII grant programs that are available to medicine, namely Academic Administrative Units in Primary Care (AAU), Faculty Development in Primary Care, and Pre-doctoral and Post-doctoral Training Programs in Primary Care.

***The absence of a dental safety net impacts how clinical services provided by dental education programs can be funded.*** Unlike medicine, there is no appreciable public financing of a dental safety net. Many low-income individuals do not qualify for limited public dental insurance through Medicaid and SCHIP programs, and essentially there are no oral health benefits in the Medicare fee-for-service program. Likewise, privately sponsored dental benefit plans often have limited coverage. As a result, dental providers are not compensated for populations that do not have the financial means to pay for services. Dental safety net providers who provide uncompensated dental care do so at their own financial risk. As significant contributors to the dental safety net, academic dental clinics (on campus and in satellite locations) provide

millions of dollars of uncompensated dental care to an ethnically diverse group of patients and to special populations, such as the elderly and people with mental, complex medical, and physical disabilities.

***Dental education has much to contribute with its experience in community-based education.*** Despite a small and underfinanced infrastructure, dental education has been prominently developing, promoting, and utilizing innovative community-based models of education. Over 92 percent of all dental curricula require community-based clinical experiences.<sup>v</sup> In 2005-06, 81 percent of all U.S. dental schools offered clinical training opportunities at off-campus locations. More than a third (21) of the 60 U.S. dental schools participate in the *Pipeline, Profession & Practice: Community-Based Dental Education program* (Dental Pipeline) that was cited as a case study in the ACTPCMD report.

## **DIRECT IMPROVEMENTS IN TITLE VII, SECTION 747 PROGRAMS**

***RECOMMENDATION 1: Congress should restore and enhance funding for Title VII, Sec. 747 programs at \$235 million for the next fiscal year and ensure that this larger appropriation is distributed more broadly across the multiple disciplines covered by these programs.***

The ACTPCMD recommendation for funding health professions programs under Title VII, Section 747 is significantly lower than the current funding level of \$254 million already approved by Congress in FY 2010.<sup>vi</sup> In truth, these programs received additional funding from a one-time appropriation of \$500 million in the American Recovery and Reinvestment Act (ARRA).<sup>vii</sup> Sixty percent (\$300 million) of ARRA funds are for investments in the National Health Service Corps (NHSC). The remainder (\$200 million) is for training programs for physicians, dentists, and nurses under Titles VII and VIII of the Public Health Services Act.

ADEA supports equitable funding across the Title VII, Sec. 747 programs. Funding for Title VII primary dental programs is essential to develop competent primary care dental providers. A primary dental provider is a professional (usually a general or pediatric dentist) who identifies, prevents, and treats a wide variety of dental diseases and conditions. Primary care dental providers are concerned with the maintenance of oral hygiene and the treatment at the earliest stages of disorders and diseases affecting the teeth and gums and associated with the jaw and face. However, for a variety of reasons, primary care dentistry is not well positioned to compete with medicine for significant funding increases. This has resulted in very modest historical growth in funding for primary care dental programs under Sec. 747. In FY 2010, funding for general and pediatric dental residency training programs was \$15 million, representing only six percent of all Title VII, Section 747 funding.

***The need for a separate dental section under Title VII.*** In 2009, both chambers of Congress in their respective health care reform proposals recognized the need to create a more level playing field for primary care dentistry by establishing a separate dental section, distinct from medicine. The Senate reform proposal establishes a separate dental funding line that would not compete with other health professions. Both proposals make academic dental institutions eligible for new grant programs currently available only to medical schools.

***RECOMMENDATION 2: The Secretary should ask Congress to modify the charge of the Advisory Committee on Training in Primary Care Medicine and Dentistry to include making recommendations directly to Congress, in addition to the Secretary.***

ADEA supports this recommendation. All health professions programs stand to benefit by elevating the reach of the ACTPCMD to the level of the U.S. Congress. This increased capacity could strengthen legislators' understanding of and support for the mission and interests of primary care training programs.

***RECOMMENDATION 3: Training grants should provide funds to develop, implement, and evaluate training programs that promote interprofessional practice in the Patient-Centered Medical-Dental Home model of care.***

ADEA supports this recommendation. In March 2008, the ADEA Board of Directors adopted as Association policy the following definition of ***dental home***:

*"A dental home is the ongoing relationship between a dental team and a patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a dental home ideally begins no later than 12 months of age and continues throughout life and includes referral to specialists when appropriate."*

The 2001 amount for interdisciplinary training projects for general and pediatric dentistry was \$1 million, compared to more than \$25 million for family and internal medicine.<sup>viii</sup> Despite the fact that overall percentages allocated are similar,

the level of funding for primary care dental interdisciplinary training programs is too small to promote the growth of these programs. As a result, academic dental institutions rely heavily on private foundation funding to support the development of interdisciplinary projects.

***RECOMMENDATION 4: Training grants should support primary care clinical training in community-based settings for providers and trainees in various disciplines, including those in Title VII programs (e.g., physicians, dentists, physician assistants), by funding proposals to recruit and support community-based educators.***

ADEA agrees with this recommendation. The new dental section Congress included in the health care reform proposals for Training in General, Pediatric, and Public Health Dentistry provides new funds that can be used for the training of oral health care providers who plan to teach in general, pediatric, or public health dentistry or dental hygiene. It would also provide financial assistance in the form of traineeships and fellowships to those who plan to teach or are teaching in primary care programs. It assists with the costs of dental faculty development programs that will be necessary to educate faculty to teach new models of care to students. The new section includes a faculty loan repayment program that could be used to attract new dental faculty to teach primary care disciplines in community-based programs.

These programs will help mitigate the impact of economic incentives that draw many dental students away from academia and into private practice. There are 369<sup>x</sup> open, budgeted faculty positions at U.S. dental schools. The biggest number of faculty vacancies occurs in general and pediatric dentistry.<sup>x</sup> The \$85,000 salary gap<sup>xi</sup> between private practice and academia has resulted in less than one percent of graduating seniors in 2008 reporting plans to enter careers as dental educators.<sup>xii</sup>

***RECOMMENDATION 5: The Bureau of Health Professions should provide support for grantees to evaluate Title VII, Sec. 747 programs and to track trainees in the long term.***

ADEA supports the development of outcome and performance measures that are developed using methodologies that are evidence-based and supported by scientific research. To facilitate the collection and management of data, ADEA encourages HRSA to provide adequate funds to grantees for online data collection. This would support and encourage the development of comparable data sets across grantees and programs. Consequently, valuable comparisons and trends data will be available to demonstrate program successes and to improve the future performance and management of Title VII programs. Representatives from academic dental and other academic health communities also need a stronger means to communicate their interests with regard to outcomes measures adopted by HRSA through a “hearings process” that is accessible and open to the public.

The HRSA workforce information and analysis program received \$2.8 million in the Consolidated Appropriations Act. Until recently, a lack of funding has made it difficult to collect information about where professionals are practicing and restricted the ability of HRSA and grantees to track and evaluate the success of Title VII programs. New requirements in the American Recovery and Reinvestment Act (ARRA) will require HRSA to monitor the financial performance of Title VII, Sec. 747 programs and ensure that they are achieving performance targets by meeting measurable outcomes.

#### **FEDERAL POLICIES NECESSARY TO SUPPORT PRIMARY CARE**

***RECOMMENDATION 6: Congress and the Centers for Medicare and Medicaid Services should restructure health care financing to attract health care providers to enter and stay in primary care careers.***

This recommendation is a prime example of a point we have made previously. Its focus is almost entirely on primary care medicine. It does not take into account the success of dentistry in recruiting, educating, and training in primary care. Nor does it consider the benefits of financing advanced education programs in dental public health as a means of reducing the overall dental disease burden and eliminating disparities in oral health.

Dental public health professionals make up a very small segment of the public health workforce overall. ADEA is encouraged by Congress’ recognition of the need for more dental public health professionals, with its inclusion of dental public health among the primary care professionals who can be trained under Title VII.

From the perspective of primary care dentistry, we urge that financing reforms encourage growth and innovation in primary care, interprofessional, and community-based education while maintaining sufficient flexibility to not unduly penalize specific primary care education programs, particularly those that are different from medicine.

***RECOMMENDATION 7: Congress and the Centers for Medicare and Medicaid Services should revise funding policies for Graduate Medical Education and other educational programs to foster and support the use of***

**community-based (non-hospital) sites for primary care training for physicians, dentists, and physician assistants.**

ADEA supports this recommendation. In 2008, the ADEA Board of Directors adopted as association policy the following statement:

*"[ADEA] strongly supports and encourages community-based dental education partnerships. These collaborations allow academic dental institutions not only to participate with other health care providers to contribute to the safety-net for underserved rural and urban communities, but also to enrich students' educational experiences."*

Academic dental institutions have been at the forefront of implementing community-based education. ADEA has seen tremendous growth in community-based dental education programs with the sponsorship of the Robert Wood Johnson Foundation (RWJF) and The California Endowment (TCE) for the *Pipeline, Profession, and Practice: Community-Based Dental Education* (Dental Pipeline) program grants. Today, 26 dental schools are submitting data on their community-based education programs to the Dental Pipeline. Some have done so voluntarily, without additional funding.

**A Snapshot of the RWJF/TCE Dental Pipeline Program**

- 344 facilities in underserved communities participated
- 63 percent of facilities were in rural areas
- Dental students provided 128,936 services in underserved communities
- Of the 68,636 patients, 55 percent were African American, Hispanic, or Native American
- 25,937 patients were seen in Federally Qualified Health Centers (FQHCs)
- FQHCs participating in program grew from 28 (14 percent) to 76 (22 percent)

Community-based dental education is an effective method of educating dental students.<sup>xiii</sup> Surveys have shown that students who complete rotations in underserved communities tend to include these populations in their patient mix when they become practicing dentists.<sup>xiv</sup> During community rotations, students get significant experience in working with a diverse patient mix, including pediatric, minority, geriatric, and special needs patients. Through exposure to this diverse patient mix, dental students expand their clinical training experiences, increase their cultural competency, and gain an understanding of their social responsibility as health care professionals. They understand the extent of the need for care among those who are underserved because they have seen it first-hand. When dental students graduate, they feel competent to address the oral health needs of underserved populations in their communities.

**RECOMMENDATION 8: Congress should expand the National Health Service Corps loan repayment programs with additional programs to address the severe primary care workforce shortages.**

ADEA agrees with this recommendation. Congress appropriated \$142 million for the National Health Service Corps (NHSC), a \$7 million increase (5.1 percent) in FY 2010. The American Recovery and Reinvestment Act<sup>xv</sup> also provided one-time funding of \$300 million to expand the NHSC and increase the number of providers participating from the current 3,800 to 8,000. The President's budget request for FY 2011 is \$169 million, which will permit another 400 NHSC clinicians to participate in the program. ADEA supports increasing the number of scholarships in the NHSC program and would like to see more scholarships extended to dental students. Academic dental institutions that make significant contributions to the dental safety net through their dental clinics should also have the option of seeking designation as D-HPSAs, allowing faculty and residents to qualify for the scholarships.

**RECOMMENDATION 9: Congress should support patient-centered Medical-Dental Home demonstration projects designed to evaluate innovative funding and reimbursement strategies that promote accessible, high-quality care while stemming the growth in health care costs.**

**High-quality care involves serving those in greatest need.** In assessing the effectiveness of new demonstration models, particular emphasis should be given to those projects that promise to reduce the barriers low-income families, minorities, remote rural populations, medically compromised individuals, and persons with special health care needs experience when trying to obtain needed services. New integrated models of care that expand roles for allied dental and other health professionals (including family physicians, pediatricians, geriatricians, and other primary care providers) as team members may be needed to address the complex needs of some patients.

**Prevention is the foundation for ensuring health and controlling costs.** New models of care that recognize prevention as the foundation for ensuring general and oral health should be emphasized in health home demonstrations. Prevention and wellness hold the promise of stemming escalating costs and treating diseases at early

stages before expensive emergencies occur. Most dental diseases are preventable, and early dental treatment is cost effective. Preventing and controlling dental diseases includes adequate financing of organized activities to promote and ensure dental public health through education, applied dental research, and the administration of programs such as water fluoridation and dental sealants. Improving oral health by multiple preventive approaches (including periodontal disease management) has saved more than \$4 billion per year in treatment costs.<sup>xvi</sup> Prevention of dental diseases ranks above HIV screening and influenza immunization in cost savings.<sup>xvii</sup> Children who receive preventive dental care early in life have lifetime dental costs that are 40 percent lower than children who do not receive care.<sup>xviii</sup> Oral cancer treatment costs in the earliest stages of the disease are estimated to be 60 percent lower than those at an advanced stage of disease.<sup>xix</sup>

## TWO HEALTH HOME MODELS IN ACADEMIC DENTAL PROGRAMS

**Students medically assess patients in health home model.** The New York University College of Dentistry (NYUCD) and College of Nursing (NYUCN) have introduced a formal, collaborative teaching program that unites dentistry and nursing. The program aims to increase students' focus in both programs on linkages between oral health and systemic health. A recent survey found that 15 percent of patients being treated at the New York University College of Dentistry (NYUCD) had medical problems that were not being addressed because they did not have a primary care provider. The program highlights the opportunities and obligations that dental students have to intervene in their patients' medical care to ensure that health problems are addressed before they worsen. Dental students in the program are learning the skills necessary to recognize, diagnose, and refer patients for care to the New York University College of Nursing (NYUCN). Emphasis is placed on disease prevention and health promotion as students are taught to assess their patients' primary and secondary preventive needs. This holistic approach to care is earning rave reviews from patients and students.

**A virtual dental home for special needs populations.** A "virtual" dental home is being piloted by The Pacific Center for Special Care at the University of the Pacific, Arthur A. Dugoni School of Dentistry (Pacific). The model is a community-based dental home model of oral health delivery system in which people receive preventive and basic therapeutic services in community settings. It utilizes the latest technology to link practitioners in the community with dentists at remote office sites. It will connect with numerous community sites throughout California. It utilizes community-based dental hygienists and dental assistants with enhanced training, skills, and experience to provide education, preventive care, and interim therapeutic treatment. These community workers also triage and ensure more complex dental patients are connected with dentists in the area. This system promotes collaboration between dentists in dental offices and community-based providers in the communities where many of these special care patients live and congregate. Many of them have complex medical, physical, or social conditions that make it difficult to get to a dentist's office. They may be institutionalized, economically disadvantaged, or living in remote areas. In addition, Pacific is organizing a high-level policy advisory committee that is composed of individuals from diverse professional, governmental, and advocacy organizations to consider the policy implications of the model and make recommendations for regulatory, reimbursement, and systems reform that facilitate its future growth.

**RECOMMENDATION 10: Congress should direct the Secretary of Health and Human Services to establish an independent health care workforce planning body that can evaluate needs and make recommendations.**

An independent workforce planning body has the potential to design national initiatives to address challenges and maximize new opportunities in current dental and health care workforce. Through a centralized information system with a uniform set of conceptual goals, multiple stakeholders could collect, disseminate, and translate workforce data into effective information for use by policy-makers. The national workforce planning body also has the potential to address politically sensitive regulatory, accreditation, licensure, and financing issues that challenge and impede current efforts to create the highly skilled, culturally competent cadre of health care professionals needed to meet the nation's health care needs. The new workforce planning body's success hinges upon an interdisciplinary governance model with the capacity to recruit credible and highly respected individuals representing a broad range of health care and other professional interests.

Representatives should include: organized health professional associations; academia (including dental and dental hygiene education programs); researchers and other experts in public health, health financing, and health care delivery; national and state accreditation and regulatory authorities; payers; legislators; private foundations; policy makers; and patients.

## CONCLUSION

ADEA recognizes and supports the basic tenet of the ACTPCMD report, which is to improve the delivery of health care through a coordinated health home that emphasizes the delivery of care in a manner that takes into account each patient's individual needs. On the other hand, some of the proposals could have unintended consequences and should be piloted on a smaller scale to determine their impact on the entire academic health and professional community. It is also important that a variety of models be piloted, since others may hold promise for enhancing the education and training of health professionals and improving the delivery of health care.

Sincerely,

Ronald J. Hunt, D.D.S., M.S.  
President

Richard W. Valachovic, D.M.D., M.P.H.  
Executive Director

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- i The American Dental Education Association (ADEA) represents all 60 dental schools in the United States, in addition to more than 700 dental residency training programs and nearly 600 allied dental education programs as well as more than 12,000 faculty who educate and train the nearly 50,000 students and residents attending these institutions. It is at these academic dental institutions that future practitioners and researchers gain their knowledge, where the majority of dental research is conducted, and where significant dental care is provided. ADEA member institutions serve as dental homes for a broad array of racially and ethnically diverse patients, many of whom are uninsured, underinsured or rely on public programs such as Medicaid and the Children's Health Insurance Program.
- ii *Distribution of Dentists in the U.S. by Region and State*, American Dental Association, 2007.
- iii There are two states (Delaware and New York) where a postgraduate year of dental education is required for licensure.
- iv Okwuje I et al. *Annual ADEA survey of dental school seniors, 2008 graduating class*. J Dent Ed, Volume 73 (8): 1009 (2009).
- v American Dental Association, Survey Curriculum – 2006-2007.
- vi Consolidated Appropriations Act of 2010, P.L. 111-117, December 2009.
- vii American Recovery and Reinvestment Act, P.L. 111-5, February 2009.
- viii HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry, First annual Report to Congress: Comprehensive Review and Recommendations: Title VII, Section 747 of the Public Health Service Act (2001).(2001).
- ix Okwuje, I, et al, Dental school vacant budgeted faculty positions, 2007-08. J Dent Ed, Volume 73 (12): 1415 (2009).
- x Chmar J et al. *Dental school vacant budgeted faculty positions, academic years 2005-2006 and 2006-07*. J Dent Ed, Volume 72 (3): 370 (2008).
- xi Figure was derived using data from the American Dental Association *Survey of Dental Practice 2007* and the American Dental Education Association 2006-07 Faculty Survey.
- xii Okwuje I et al. *Annual ADEA survey of dental school seniors, 2008 graduating class*. J Dent Ed, Volume 73 (8): 1009 (2009).
- xiii DeCastro JE et al. *Clinical competence of graduates of community-based and traditional curricula*. J Dent Ed, Volume 69 (12):1324-31 (2005).
- xiv Baumeister SE et al. *What influences dental students to serve special care patients?* Spec Care Dent, Volume 27 (1):15–22 (2007).
- xv American Recovery and Reinvestment Act, P.L. 111-5, February 2009.
- xvi Dolatowski T. *Confronting the Burden of Dental Disease: Employers Hold Key to Lessening the Effects*. Delta In-Depth, An Article Series for Producers, Delta Dental Plans Association. Available at [www.deltadental.com](http://www.deltadental.com), accessed December 2008.
- xvii Silverstein S, Garrison HH, Heinig SJ. *A few basic economic facts about research in the medical and related life sciences*. Federation of American Societies for Experimental Biology, Volume 9:833-840 (1995).

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<sup>xviii</sup> Sinclair SA, Edelstein B. *Cost effectiveness of Preventive Dental Services*. Washington, DC: Children's Dental Health Project, February 2005.

<sup>xix</sup> Zavras A, Andreopoulos N, Katsikeris N, Zavras D, Cartsos V, Vamvakidis A. *Oral cancer treatment costs in Greece and the effect of advanced disease*. BMC Public Health 2:12 (2002). Available at [www.biomedcentral.com/1471-2458/2/12](http://www.biomedcentral.com/1471-2458/2/12).