ADEA American Dental Education Association
Charting Progress
JUNE 2006

A Monthly Newsletter from Executive Director Richard W. Valachovic, D.M.D., M.P.H.

This month's Charting Progress, *a letter to members from Dr. Rick Valachovic, Executive Director of the American Dental Education Association, offers thoughts about the value of advocacy for dental education--and each member's responsibility to participate in the process . . . .*

The Art of Advocacy

"If you, as my constituent, do not ask me to support your programs, you can be certain that some other constituent, with different interests, will."

I am writing this month about the art of advocacy. Notice I didn't say the "science" of advocacy. In many ways advocacy is an acquired taste, one that is performed better when it is practiced often. It is an ongoing process to educate, motivate, and activate individuals and institutions for the purpose of influencing the formulation of public policy. And, in my opinion, it is an integral part of the democratic system in which we Americans live. Consequently, it is a necessary skill for dental educators and researchers, as well as a professional responsibility.

Like it or not, government plays a major role in our lives. Indeed, government in large measure finances and regulates higher education and the delivery of health care. Therefore, decisions made by elected and appointed officials in Washington or in state capitals nationwide affect academic dentistry and the oral health of U.S. citizens. Enhancing what is beneficial or mitigating what is harmful through the ongoing education of these elected and appointed officials is the ultimate objective of advocacy.

Win or Lose, Advocacy is Essential -- ADEA takes very seriously the responsibility to advocate on behalf of its members' interests. Those interests include increasing federal funding for our programs and emphasizing to Congress and the federal government the importance and value of oral health. Let me offer two contrasting examples of government actions that have affected our dental schools, advanced education programs and allied education programs, which we commonly refer to as "academic dental institutions," one positively and other in a severely negative manner. On both issues ADEA members mounted impressive advocacy campaigns. The first is a bill that was signed into law in 1990, the Ryan White CARE Act. It provides federal monies for the care of persons living with HIV/AIDS. The law presently includes two programs critical to academic dental institutions: 1) the Dental Reimbursement Program and 2) the Community-Based Dental Partnership Program. These programs reimburse academic dental institutions for the oral health care services they render to individuals living with HIV, either in academic dental institutions or in off-site community settings. Since 1991, for instance, the Dental Reimbursement Program has provided more than $115,000,000 for oral health care provided to HIV/AIDS patients, with nearly $50 million going to dental schools and over $65 million going to hospital-based dental residency programs. These programs would not have happened without the strong advocacy role provided by ADEA.

Advocacy doesn't always result in positive outcomes. For instance, a harmful government action in 2003 by the Centers for Medicare and Medicaid Services, an agency within the U.S. Department of Health and Human Services, effectively ended Graduate Medical Education (GME) reimbursement to dental schools for the purpose of educating and training residents in their schools and clinics. Twenty-six of the 32 dental schools that had GME-funded residency programs have lost or will lose by October 2006 this key federal revenue source for education and training.

Win or lose, advocacy by ADEA and its members is essential to our

profession. Responsibility for this vital activity can either be embraced by dental educators and researchers or can be abdicated by them. ADEA chooses to embrace advocacy and be as artful at it as possible.

Advocacy Infrastructure -- ADEA has a professional staff of advocates and policy analysts to advance legislative and public policy priorities. This professional team makes up the ADEA Center for Public Policy and Advocacy (CPPA). The priorities that the team pursues are defined by the ADEA Board of Directors based on recommendations from the National Oral Health Advocacy Committee (NOHAC), a joint committee of members from ADEA and the American Association for Dental Research (AADR). NOHAC objectively prioritizes issues to advance the needs of academic dentistry and dental research. The committee advises the ADEA and AADR Boards of Directors on advocacy issues and assists CPPA staff in promoting, building, and mobilizing an effective grassroots advocacy network. The grassroots network of ADEA and AADR members in academic dental institutions nationwide is called the AADR/ADEA National Advocacy Network. The ADEA Board of Directors usually establishes the priorities for the Association. Occasionally, though, policy decisions require broader involvement, and at that point, the ADEA House of Delegates reviews and debates policy matters during its business meetings at the ADEA Annual Session.

ADEA's CPPA staff routinely visit with Members of Congress, their legislative staffs, and the Executive Branch of government to discuss important legislation and policies affecting academic dentistry. But, individual ADEA members do also. To educate members in the art of advocacy and to prepare them for their conversations with their two U.S. Senators and member of the House of Representatives, ADEA sponsors seminars both in Washington and around the country at dental schools. Over 500 dental educators and researchers have participated in these trainings over the last ten years. Also, more than 1,000 dental students have received advocacy training as part of the ADEA/ASDA National Dental Student Lobby Day, a joint venture of ADEA and the American Student Dental Association. These seminars help educators, researchers, and students hone their advocacy skills and deliver effective messages to Congress.

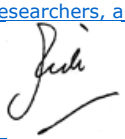
Much of ADEA's advocacy centers on securing federal dollars that support education, training, and research programs that benefit academic dental institutions, residency training programs, dental researchers, and students. Examples of these programs include grants supporting residency training for dental public health and general and pediatric dentistry and grants to conduct dental and biomedical research and programs that assist students to attend and pay for their education. These programs fall under what is referred to in the federal budget as "domestic discretionary spending." About $960 billion of the total federal budget ($2.47 trillion in fiscal year 2006) is devoted to discretionary (domestic and security) spending. The remainder of the federal budget is called "mandatory spending." ADEA and others in its coalition monitor all of these programs.

Given the magnitude of what's going on it's easy to see that above all else, advocacy requires persistence and constancy. Nothing happens quickly in Washington. It literally can take years to convince Congress to do something about a legislative priority. An example is the funding for the Dental Health Improvement Act, which assists states in addressing their dental workforce issues. Enacted in 2001 after years of advocacy by ADEA and a coalition of dental groups, including the American Dental Association, the Dental Health Improvement Act did not receive funding from Congress until fiscal year 2006! Funding would not have happened even then had not ADEA members and coalition partners practiced dogged advocacy. The networks ADEA has put in place do, indeed, work, but require an extraordinary level of diligence.

Advocacy Tools -- Any ADEA or AADR member may join our Volunteer Advocacy Coordinators.

Those of you who have a case of "Potomac fever" may apply for a fellowship at ADEA generously sponsored by Sunstar Butler Inc., the *ADEA State Issues Update.* Its purpose is to keep ADEA members and others abreast of what is happening in states and state capitals on issues and events of interest to the academic dental community. Any ADEA member may request to be placed on the distribution lists for these publications or access them on ADEA Advocacy Alerts by communicating with their officials as constituents is the most influential advocacy possible. More often than not, the **ADEA Advocacy Alerts** require members to take action immediately to let their elected officials know the public policy position of dental educators and researchers on a given issue.

The Value of Advocacy -- Only about 8 percent of the U. S. discretionary domestic budget is spent on education, training, and social services programs. This includes research funded by the National Institutes of Health (NIH), the premiere biomedical research organization in the world. Approximately $28 billion is spent on NIH research. Of this amount, $389 million is devoted to the National Institute of Dental and Craniofacial Research (NIDCR), which is the scientific underpinning of the dental profession. NIDCR is the only NIH institute that focuses entirely on research and research training programs directly relevant to the clinical practice of dentistry. In the 10 years that I have had the privilege to serve the American Dental Education Association, 52 dental schools have been awarded NIDCR grants valued at about $1.08 billion. Funding in this amount would not have been available had dental educators, dental researchers, and



others not advocated so effectively. Learn more about NIDCR

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