ADEA | THE VOICE OF DENTAL EDUCATION

AMERICAN DENTAL EDUCATION ASSOCIATION

The mission of ADEA is to lead institutions and individuals in the dental education community to address contemporary issues influencing education, research and the delivery of oral health care for the overall health and safety of the public.

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June 1, 2020

The Honorable Lamar Alexander
Chair
Committee on Health, Education, Labor and Pensions
United States Senate
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your leadership during the novel coronavirus (COVID-19) pandemic. The Provider Relief Fund established in the CARES Act (PL 116-126) and enhanced in the Paycheck Protection Program and Health Care Enhancement Act (PL 116-139) is an essential bridge to assist health care providers, including dental school clinics, to continue to provide high-quality care to patients.

On behalf of the 68 dental schools and over 300 dental hygiene education programs in the United States, I am writing to share with you our role in community health and to seek your assistance in the next set of challenges. Each of these dental schools and dental hygiene programs operates a patient care clinic, which serves to educate and train oral health professionals.

Before these schools and programs can fully reopen for patient care, most will require some structural modification to clinic spaces and changes to infection control protocols. For dental students, patient care experience and attainment of competence is obtained in dental clinics, which are in all dental schools. These clinics must include most of the major service areas of a hospital and adhere to the rigorous federal and state guidelines that protect the health and safety of the public, much like hospitals do. Dental schools operate full clinical facilities with all the necessary treatment rooms and surgical suites, including areas for sterilization, diagnostic services such as radiology and pathology, and business operations. In contrast, medical schools conduct the majority of their clinical teaching and training in separate hospitals or affiliated academic health centers and do not require the stringent protective guidelines in their education buildings that are in place at dental school clinics.

During this crisis, some dental school clinics have even been retrofitted to accommodate hospital beds to assist the academic medical centers, which are operating above capacity. Also, dental faculty and residents who have remained on campus to treat dental emergencies have volunteered in many medical centers or hospitals to evaluate patients coming to the ER and perform other duties within their scope of practice (administering COVID-19 tests, for instance).

Dental schools are part of their local communities' health care safety net and are a valuable untapped health care resource that could be used more at this time, and in future public health emergencies. Dental school clinics serve the same geographic patient populations as their medical colleagues, providing

care at reduced rates. According to the Health Resources and Services Administration, the United States has 6,300 dental shortage areas where 59 million people do not have adequate access to dental care. In academic year 2016-17, U.S. dental school clinics provided care during 2.7 million patient visits. A large number of the individuals who receive dental care in these clinics are members of underserved populations and do not have private insurance or the ability to pay private practice fees.

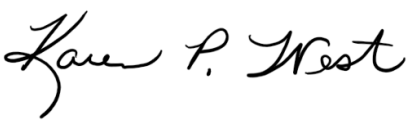
Therefore, ADEA respectfully requests that as you finalize the Senate version of the next COVID-19 response legislation, you include dental school and dental hygiene education program clinics in the eligibility for grants to expand, enhance and modernize these important community health care facilities, which will allow them to continue their missions during this health crisis and beyond. Otherwise, oral health care for underserved and medically compromised patients, as well as the low-income population, will go unmet due to the high costs associated with ensuring adequate safety precautions for the delivery of care.

Also, the research enterprise is an integral component within dental education and has also been shut down because of campus closures or refocusing on activities to improve understanding of the COVID-19 disease. ADEA is working closely with our colleagues at the American Association for Dental Research, who have noted that it will be challenging to restart much of the dental research work and institutions will require additional financial support to reopen research facilities and replace repurposed equipment, supplies and subjects. The National Institute of Dental and Craniofacial Research has also turned its attention to COVID-19-related research and is therefore in need of $90 million to carry out this new research agenda without diminishing other priority dental, oral and craniofacial research.

Finally, ADEA has joined with our partners at the American Council on Education and our medical colleagues in expressing concern that when campuses resume full operations, they may be facing huge transactional costs associated with defending against COVID-19 spread lawsuits, even when they have done everything within their power to keep students, employees and visitors safe. To blunt the chilling effect this will have on their ability to reopen, we ask that Congress enact temporary COVID-19-related liability protections for higher education institutions, including their health care facilities and research enterprises, which are engaged in every sector of critical infrastructure necessary to support American communities, and their faculty, staff and volunteers. These protections should be conditioned on following applicable public health standards, and they should preserve recourse for those harmed by individuals who engaged in egregious misconduct.

If you have any questions or would like more information, please do not hesitate to contact me or Tim Leeth, ADEA Chief Advocacy Officer, at leetht@adea.org or 202-236-5354.

Sincerely,



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