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Public Health Subcommittee Senate Health, Education, Labor and Pensions Committee
"The Crisis in Children's Dental Health: A Silent Epidemic"
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Introduction
The American Dental Hygienists' Association (ADHA) appreciates this opportunity to submit testimony regarding "The Crisis in Children's Dental Health: A Silent Epidemic." ADHA applauds the Senate Committee on Health, Education, Labor and Pensions for holding this important Public Health Subcommittee hearing on children's oral health. ADHA is hopeful that henceforth, whenever Senators think of general health, they will also think of oral health. As today's lead-off witness, former Surgeon General David Satcher, will confirm, oral health is a fundamental part of overall health and well-being.

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. Please visit the ADHA web site at www.adha.org.

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, all Americans can 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. 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 and ADHA believes that increased utilization of dental hygienists is an important part of that solution.

ADHA Supports Senate Legislative Efforts to Address the Nation's Oral Health Crisis
ADHA is pleased that legislation has been introduced by members of the Senate Health Committee to address the national epidemic of oral disease among our nation's children. In particular, the strong leadership of Senator Jeff Bingaman on oral health issues is greatly appreciated by ADHA and by the New Mexico Dental Hygienists Association. Senator Bingaman's devotion to improving the oral health of children is inspiring and ADHA is proud to support S. 1626, the Children's Dental Health Improvement Act, introduced in November 2001 by Senator Bingaman.

ADHA also supports companion legislation in the House of Representatives, H.R. 3659, introduced by Representatives John Murtha and Fred Upton in January 2002. More than 40 organizations have endorsed S. 1626 and H.R. 3659, including non-dental groups such as the American Public Health Association, the Association of Maternal and Child Health Programs and the March of Dimes. This legislation is designed to improve the access and delivery of oral health services to the nation's children through Medicaid, the State Children's Health Insurance Program (SCHIP), the Indian Health Service and the nation's safety net of community health centers.

ADHA also supports S. 2202, the Perinatal Dental Health Improvement Act of 2002. Introduced in April 2002 by Senator John Edwards and Senator Bingaman, this legislation recognizes the link between severe periodontal disease in pregnant women and pre-term low birth weight babies.

ADHA additionally supports S. 998, the Dental Health Improvement Act, introduced in June 2001 by Senators Susan Collins and Russ Feingold. This legislation would expand the availability of oral health
services by strengthening the dental workforce in designated underserved areas. The Senate passed S. 998 in March 2002 as part of the Health Care Safety Net Amendments. ADHA is hopeful that this important legislation will be enacted into law before Congress recesses for the August district work period.

ADHA applauds this Committee for its increasing interest in oral health issues and pledges to work with members of this Committee and all lawmakers to enact the above-mentioned oral health efforts into law.


Former U.S. Surgeon General David Satcher 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. 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.

Addressing the Silent Epidemic of Oral Disease

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.

This nation must address the inequality in oral health status that is pervasive across America. All Americans, regardless of economic status or geographic location, should enjoy the benefits of good oral health. Indeed, ADHA maintains that "oral health care -- a fundamental part of total health care -- is the right of all people."

Please see Attachment A, the ADHA Access to Care Position Paper, in which this belief is enunciated.

ADHA is committed to working in partnerships at all levels with policymakers, parents, advocates, additional health care providers -- both dental and non-dental -- and others in order to improve general health and well-being through the promotion of optimal oral health. Fundamental to this goal is work to promote awareness of the fact that oral health is an integral part of total health and work to increase access to oral health care services.

ADHA further believes that we must focus first on our nation's most precious resource -- our children. That is why it is vital that we buttress the innovations states are pioneering with respect to Medicaid and SCHIP, such as the recent trend toward recognition of dental hygienists as Medicaid providers.

Improving the Nation's "Oral Health IQ"

This U.S. Senate hearing today is a critically important step forward in the effort to change perceptions regarding oral health and 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 Health Committee 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. Other diseases with oral manifestations are diabetes, HIV and osteoporosis. Bulimia nervosa and anorexia nervosa also exhibit oral manifestations, such as localized enamel erosion. Scientific evidence is now building which demonstrates that periodontal (gum) disease also may be a risk factor for pre-mature, low birthweight babies. Pregnant women who have periodontal disease may be seven times more likely to have a baby that is born too early and too small. Caring for low birthweight babies and their mothers is extremely expensive. If the public, policymakers and health providers are educated about these links, their appreciation for the importance of oral health will be heightened.

**Additional Entry Points into the Oral Health Care Delivery System Are Needed**

The current oral health care system is not meeting the oral health care needs of all Americans. Additional access points must be added, particularly for those who are economically disadvantaged. Indeed, despite the proven benefits of preventive oral health measures, less than one in five Medicaid-eligible children (4.2 million out of 21.2 million) actually received preventive oral health services in 1993, according to a 1996 U.S. Department of Health and Human Services report entitled Children's Dental Services Under Medicaid. And only one in four Native American children received any dental care in a recent one-year period according to the Indian Health Service. Moreover, only 41% of adults (25 years and older) with less than a high school education had an annual dental visit while only 74% of adults with at least some college had an annual dental visit (NHIS 1997).

Clearly, the current structure of the oral health care system needs to change. ADHA believes that additional access points to oral health care must be utilized. The vast majority of dental hygienists currently work in a dentist's private practice. Others work, for example, in public health settings, educational institutions, as well as in research, and in business. Interestingly, in 1948 only approximately 50% of dental hygienists worked in private dental offices. Others worked in schools, hospitals, public health facilities and other settings. Clearly, dental hygienists have lost significant outreach avenues over the years. Reversing this trend would no doubt help address the serious access to care problems confronted by too many Americans.

ADHA urges policymakers to facilitate additional access points to the oral health care delivery system.

**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. ADHA urges that the Senate Health Committee work to strengthen and enhance Medicaid and SCHIP dental benefits and ADHA looks forward to a future in which all Americans have dental health insurance coverage.

Even those who have dental insurance coverage, particularly Medicaid-eligible children, are not assured of access to care. ADHA is committed to increasing the percentage of Medicaid and SCHIP-eligible children who receive oral health services. 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.

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 that the position of Chief Dental Officer at the Centers for Medicare and Medicaid Services (CMS) has apparently been made permanent. Given the increasing recognition of the importance of oral health and the key role of CMS's Chief Dental Officer, it is imperative that this position be institutionalized. In addition, ADHA urges that this Committee 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. To enable NIDCR to continue and to build upon its important research mission, ADHA urges that NIDCR be maintained as an independent institute at the National Institutes of Health.

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" and "poor children have five times more untreated dental caries (cavities) than children in higher-income families." 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 schools, medical clinics, after school programs and nursing homes etc. would promote increased use of dental services among low income persons. 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.

Dental hygienists are prevention specialists who are licensed in each of the fifty states and the District of Columbia. In order to be eligible for a license, prospective practitioners must graduate from one of the 260 dental hygiene education programs accredited by the American Dental Association Commission on Dental Accreditation. The accreditation standards for dental hygiene education programs require graduates to be
competent in conducting thorough periodontal and dental examinations, developing a dental hygiene diagnosis and treatment plan, and making appropriate referrals for additional treatment needs. Further, candidates for dental hygiene licensure must pass a national written examination and a regional or state clinical examination. In addition, 48 states require continuing education for licensure renewal.

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.

Increased Access to Preventive Oral Health Services is Key to Improving the Nation's Oral Health

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, tooth decay -- which is an infectious transmissible disease -- still affects more than half of all children by second grade. Clearly, more must be done to increase children's 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 schools, 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. To illustrate, here are a few examples of limitations on practice settings outside of the private dental office. In West Virginia, dental hygienists are limited to industrial clinics and schools; in Illinois, dental hygienists are limited to mental health institutions and nursing homes and in Arkansas, dental hygienists are limited to prisons.

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.

By the early 1990s, California and Washington recognized dental hygienists as Medicaid providers of oral health services and provided direct reimbursement for their services. Over the last several years, an additional five states followed: Oregon in 1999; Colorado, Connecticut, and Missouri in 2001; and Maine in 2002. 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.

States should heed the recommendations of organizations such as the Illinois Center for Health Workforce Studies which called for "new solutions" to the problem of limited access to oral health care services for Medicaid and SCHIP children. In February 2001, the Center called for "modifying the [Illinois] state practice act to allow dental hygienists to provide preventive care in public health settings without a dentist on-site."

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. Rest assured that ADHA will continue to work to expand the practice settings of dental hygienists so that additional people may access needed oral health services. Dental hygienists should be viewed as essential entry points into the oral health care system. Physicians and dental hygienists should partner to ensure patients receive oral health care services. ADHA also will work to ensure that this dental hygiene outreach is linked appropriately with the restorative services of dentists.

**Public-Private Partnerships are Critical to Addressing the Nation's Silent Epidemic of Dental Disease**

An innovative public-private partnership in South Carolina called Health Promotion Specialists (HPS) provides a shining example of the effectiveness of public-private partnerships. This partnership has performed dental screenings for over 33,000 children during the past year and has delivered preventive dental hygiene care to over 12,000 children. Further, many thousands of children have been linked to dentists for the provision of restorative care.

This school-based oral health program is a collaborative effort between school health officials, community support services, dentists, dental hygienists and the state health agency. In fact, in February 2002 both the South Carolina Dental Association and the South Carolina Dental Hygiene Association joined with the South Carolina Department of Education and the South Carolina Department of Health and Environmental Control to endorse this type of public/private partnership. Upon return of a signed parental consent form, HPS provides oral hygiene instructions and preventive services that include cleanings, the application of fluoride and the application of dental sealants on permanent back teeth.

HPS provides these services at regular intervals as part of a continuing care program. HPS works to refer children who need restorative services to local dentists, clinics and available mobile dental vans. Public-private partnerships such as the school-based oral health program administered by HPS are vital to the oral health of America.
To illustrate the effectiveness of such partnerships and the dramatic impact these partnerships can make in the life of a child, ADHA wishes to share one of the many success stories realized through this program. A child in Marlboro County had been in dental pain for more than three months before HPS arrived. The school nurse and the school principal had been unable to get dental care for him. HPS arranged for a mobile dental van to go to Marlboro County to see this first grader. On the day the dental hygienist was to leave the school, the student saw her in the school hallway, hugged her, and gave her a big smile, and said I don't hurt anymore." Because of this public private partnership, that first grader is now able to focus on first grade instead of pain in the oral cavity. That's what makes it all worthwhile and ADHA hopes that lawmakers, educators, public health officials, dentists, dental hygienists, advocates, families and all those who care about the nation's oral health to come together in order to improve the health of the American people.

Another example of a public-private partnership that successfully increased access to care occurred recently in Oregon. This partnership is particularly heartening in that it involved both the Oregon Dental Association and the Oregon Dental Hygienists' Association. At the suggestion of the Oregon state legislature, these two associations came together to develop a proposal to increase access to care by relieving certain dental hygiene supervision requirements.

A Task Force created by the two associations proposed the creation of a Limited Access Permit for experienced dental hygienists. This proposal was subsequently passed, without a single dissenting vote, by the Oregon legislature in 1997. Currently, approximately 20 dental hygienists hold a Limited Access Permit, which enables a dental hygienist to provide preventive oral health services in certain settings without a prior dental visit. Permit holders must have completed at least 5,000 hours of supervised dental hygiene clinical practice in the five years previous to receiving their permit; they also must complete forty classroom hours in specified courses. Twelve hours of continuing education are required to maintain the permit; this is in addition to the twenty-four hours required to maintain the dental hygiene license. Further, a Limited Access Permit Dental Hygienist must refer a patient annually to a dentist who is available to treat the patient. There are approximately 100 dental hygienists currently in the process of qualifying for the Limited Access Permit. The oral health of Oregonians will be better served when these candidates obtain their permits.

To illustrate, one dental hygienist holding a Limited Access Permit works weekly in an extended care facility with an on-site dental clinic. Depending on their dental hygiene treatment needs, she sees six to ten patients a day. Her services are appropriately linked to the services of a dentist, who visits the extended care facility at least once monthly to provide needed services. Over a given year, this hygienist provides care to approximately 400 patients in their place of residence. The resident and/or guardian's private insurance or Medicaid pays for the cost of their care. Importantly, the large majority of these patients are unable to leave the facility to access dental care.

Initially, provision of dental hygiene services under the Limited Access Permit was largely restricted to extended care facilities, including adult foster care and assisted living. In 2001, however, the Oregon legislature broadened the range of facilities in which Limited Access Permit holders could provide services to include public and private schools (grades kindergarten through twelve), pre-schools, correctional facilities and job training sites. This confirms the increasing trend among states to explore ways to increase access to care through maximum utilization of the experience, education, and expertise of the dental hygienist.

Conclusion
In closing, the American Dental Hygienists' Association appreciates this opportunity to provide written testimony on "The Crisis in Children's Dental Health: A Silent Epidemic." ADHA looks forward to a future in which the education, experience and expertise of dental hygienists are appropriately recognized and utilized; this will increase 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.