Excerpts from AAPD “Red Book” on the oral health crisis primarily affecting poor children in our country

### AAPD 2005 Top Legislative Priority Requests

**Federal Appropriations for FY 2006**

| Workforce Goal | 1. Appropriations for Title VII Pediatric Dentistry, consistent with FY 2004 and FY 2005 $5.5 million earmark, and seek HRSA expansion of grant opportunity in FY 2006 for faculty development and dental faculty loan repayment program (per FY 2005 House report language). |

**Federal Authorizations**

| Workforce Goal | 1. Title VII reauthorization — Continue present authority and expand for pre-doctoral curriculum development, faculty development, innovative projects (such as distance learning) as well as create authority for loan repayment for dental faculty consistent with joint AAPD-ADEA-ADA Title VII reauthorization proposal developed in 2004. |

**Federal Health Care Entitlement Legislation**

| Medicaid Dental Reform Goal | 1. Ensure that any federal Medicaid reform legislation retains a mandatory children’s EPSDT benefit while providing reasonable flexibility to states. Work with dental organizations to develop the most effective strategy for dental benefits while partnering with larger Medicaid coalitions as appropriate. |

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2 year old with rampant decay, in pain.

20 month old, early childhood caries. Does not eat well. Low weight for age. 9 teeth involved.

This photo shows an 18 month old baby with six decayed teeth and abscesses. Unfortunately children with such severe decay are often in pain for weeks before help is sought.

These photos show the desired outcome—either a healthy mouth through preventive practices, or proper restorations for children who had severe dental problems and were able to obtain appropriate dental care (in this case, stainless steel crowns on primary or baby teeth). Proper dental treatment affords these children the opportunity to have their permanent teeth erupt into a healthy, comfortable and decay-free mouth with no space loss. The availability of early comprehensive care reduces the likelihood of more serious health problems in the future. Early care will also reduce the cost of future health care.
HRSA TITLE VII PEDIATRIC DENTISTRY APPROPRIATIONS

REQUEST: Continue the appropriation earmark for Pediatric Dentistry provided by Congress in the FY 2004 and FY 2005 appropriations, within overall support in FY 2006 for the HRSA Title VII Pediatric and General Dentistry Training program. The overall need for the Pediatric and General Dentistry program is $15 million, which is also supported by the American Dental Association, the American Dental Education Association, and the Children’s Dental Health Project, and was recommended in the November 2001 Report of the HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry.

BACKGROUND: Pediatric Dentistry training is critical to meeting the nation’s oral health care needs. The two-year Pediatric Dentistry residency program, taken after graduation from dental school, immerses the dentist in scientific study enhanced with clinical experience. This training is the dental counterpart to general pediatrics. The trainee learns advanced diagnostic and surgical procedures, along with child psychology and clinical management, oral pathology, pharmacology related to the child, radiology, child development, management of orofacial trauma, caring for patients with special health care needs, conscious sedation, and general anesthesia. Since children’s oral health is an important part of overall health, pediatric dentists often work with pediatricians, other physicians, and dental specialists. Healthy children, as well as hospitalized and chronically ill children or children with disabilities, often benefit from a team approach.

Twenty-five percent of the pediatric population experiences 80% of the dental disease, which is concentrated in low-income, minority populations. Access to dental providers is critical for Medicaid and SCHIP populations. Pediatric dentists provide more complete and less sporadic care to Medicaid and SCHIP populations. Of the remainder entering private practice, these individuals indicate that they will serve Medicaid, SCHIP and other low-income populations. Upon graduation, 40% of trainees are entering “non-traditional” areas such as public health, academics, or clinics focused on serving low-income populations. Of the remainder entering private practice, these individuals indicate that they will serve Medicaid, SCHIP and other low-income populations. Of the remainder entering private practice, these individuals indicate that they will serve Medicaid, SCHIP and other low-income populations. Of the remainder entering private practice, these individuals indicate that they will serve Medicaid, SCHIP and other low-income populations. Of the remainder entering private practice, these individuals indicate that they will serve Medicaid, SCHIP and other low-income populations. Of the remainder entering private practice, these individuals indicate that they will serve Medicaid, SCHIP and other low-income populations. Of the remainder entering private practice, these individuals indicate that they will serve Medicaid, SCHIP and other low-income populations.

PROBLEM: While there is a clear shortage of pediatric dentists, the U.S. is not training enough pediatric dental health care providers to meet the increasing need for pediatric oral health care services. Training slots have not kept pace with demand. 40% of all applicants to Pediatric Dentistry training positions for 2005-2006 were turned away due to a lack of positions. Some training programs have 25 times the number of applicants that can be accommodated.

Because of increased attention to this problem—and primarily as a result of Title VII support—since 1998 first year positions have increased from 180 to 278, although this is just a small dent in the overall need. The decreased number of available pediatric dentists is adversely impacting both private practice and academics. Many positions for pediatric dentists remain open in private practice, public health clinics, dental schools, residency training programs, corporate employment, and government service.

JUSTIFICATION: The authority to fund Pediatric Dentistry Residency training under Title VII was enacted under the Health Professions Education Partnership Act of 1998. This expanded the existing General Dentistry training authority, providing three year “start up” funds to either increase Pediatric Dentistry positions at existing programs or initiate new programs. In the first five years of funding, nearly $13 million has been allocated to 40 Pediatric Dentistry programs, including seven new programs. Every program that can be funded is critical, as Pediatric Dentistry residency programs provide a significant amount of care to underserved populations. Two-thirds of the patients treated in these programs are Medicaid recipients.

Pediatric Dentistry Title VII grantees are meeting stated federal goals. Results from a 2003 study by the Children’s Dental Health Project (funded by the AAPD Foundation) indicate that 30% of residents in Title VII pediatric dentistry programs are under-represented minorities (URM), far above the 11% URM that graduate from dental schools. Residents in these programs spend an average of 20% of their training time delivering care in underserved communities. Upon graduation, 40% of trainees are entering “non-traditional” areas such as public health, academics, or clinics focused on serving low-income populations. Of the remainder entering private practice, these individuals indicate that they will serve Medicaid, SCHIP and other low-income populations. Of the remainder entering private practice, these individuals indicate that they will serve Medicaid, SCHIP and other low-income populations. Of the remainder entering private practice, these individuals indicate that they will serve Medicaid, SCHIP and other low-income populations. Of the remainder entering private practice, these individuals indicate that they will serve Medicaid, SCHIP and other low-income populations. Of the remainder entering private practice, these individuals indicate that they will serve Medicaid, SCHIP and other low-income populations. Of the remainder entering private practice, these individuals indicate that they will serve Medicaid, SCHIP and other low-income populations.

This requested amount also contemplates expanded funding for innovative projects, faculty development (including faculty loan repayment), academic program development, and pre-doctoral education in pediatric dentistry.

MEDIACAID DENTAL REFORM

REQUEST: Support the Senate budget language that restores Medicaid funding and creates a bipartisan commission to recommend appropriate reforms.

On March 17, 2005, the United States Senate voted 52-48 in favor of an amendment to the FY 2006 Budget Resolution that struck “reconciliation instructions” to the Senate Finance Committee to cut the Medicaid program by $15 billion over the next five years. The AAPD supported this amendment because although oral health care is not the cause of Medicaid budget growth, the dental provider community is greatly concerned that significant Medicaid reductions could lead to a weakening of the mandatory program for children (EPSDT). As expressed in a March 2, 2005 letter to the House and Senate Budget Committees signed by 19 national dental organizations, including the American Academy of Pediatric Dentistry, it was recommended that:

“Rather than using blunt funding cuts, we hope that you will first explore all reasonable options to ensure the fiscal viability of the program while at the same time preserving the core mission of the program: providing desperately needed care, including dental care, to our nation’s most vulnerable citizens. We offer our assistance to you in achieving this goal.”

In dentistry, there is strong evidence of how to reform dental Medicaid programs to make them work effectively for the children in need. Examples of successful reforms are documented in the American Dental Association’s 2004 Access White Paper entitled “State and Community Models for Improving Access to Dental Care for the Underserved.” This paper is aimed at helping states and communities create market-based solutions to ease unmet needs for dental care among large groups of Americans, and cites innovative and successful Medicaid dental reforms in states such as Michigan, Alabama, and Tennessee. The AAPD would be pleased to provide additional information about any of these “models” of reform. For Medicaid dental programs, we know what works—now is the time for a federal-state partnership to emulate these models across the country. Pediatric dentists have a strong commitment to making Medicaid work.

TITLE VII HEALTH PROFESSIONS TRAINING REAUTHORIZATION PROPOSAL

REQUEST: Expand authority for faculty development and academic unit support in primary care general and pediatric dentistry programs. Create a dental faculty loan repayment program with priority to primary care faculty (pediatric and general dentists). This proposal is strongly supported by the AAPD, the American Dental Association, and the American Dental Education Association.

JUSTIFICATION: HRSA’s Advisory Committee on Training in Primary Care Medicine and Dentistry recommended in its November 2001 report to Congress the following: “Broader Support for Dentistry.” General dentistry and pediatric dentistry programs need to be able to compete for funding for academic units, faculty development and residency support. Current legislative language does not address the eligibility of general and pediatric dentistry to compete for these categories of support, and should be amended.”

- Schools of dentistry in the U.S. are experiencing a faculty shortage crisis, with significant difficulties in recruiting qualified individuals to fill currently vacant positions. One of the most critical factors is economic, with the combination of staggering student loan debt and a “buyers market” for private practice opportunities in areas such as pediatric dentistry that make it difficult for dental education institutions to recruit new faculty.