

**DENTAL CRISIS IN AMERICA: THE NEED TO
EXPAND ACCESS**

HEARING

BEFORE THE

SUBCOMMITTEE ON PRIMARY HEALTH AND AGING

OF THE

COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

ON

EXAMINING DENTAL CRISIS IN AMERICA, FOCUSING ON THE NEED TO
EXPAND ACCESS

FEBRUARY 29, 2012

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C O N T E N T S

STATEMENTS

WEDNESDAY, FEBRUARY 29, 2012

Page

COMMITTEE MEMBERS

Sanders, Hon. Bernard, Chairman, Subcommittee on Primary Health and Aging, opening statement	1
Mikulski, Hon. Barbara A., a U.S. Senator from the State of Maryland	3
Franken, Hon. Al, a U.S. Senator from the State of Minnesota	27
Bingaman, Hon. Jeff, a U.S. Senator from the State of New Mexico	44
Rockefeller, Hon. John D., IV, a U.S. Senator from the State of West Virginia, prepared statement	51

WITNESSES

Edelstein, Burton L., D.D.S., MPH, Professor of Dentistry and Health Policy and Management, Columbia University, New York, NY	4
Prepared statement	6
Gehshan, Shelly, MMP, Director, Pew Children's Dental Campaign, Pew Center on the States, Washington, DC	9
Prepared statement	11
Whitmer, Grant, MSM, Executive Director, Community Health Centers of the Rutland Region, Rutland, VT	15
Prepared statement	17
Folse, Gregory J., D.D.S., President, Outreach Dentistry, Lafayette, LA	20
Prepared statement	22
Fogarty, Christy Jo, RDH, MSOHP, Licensed Dental Hygienist, Licensed Dental Therapist, Children's Dental Services, Farmington, MN	27
Prepared statement	29

ADDITIONAL MATERIAL

Statements, articles, publications, letters, etc.:	
Academy of General Dentistry (AGD)	53
American Academy of Pediatric Dentistry (AAPD)	55
American Dental Association (ADA)	62
American Dental Hygienists' Association (ADHA)	71
Hispanic Dental Association (HDA)	76

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WEDNESDAY, FEBRUARY 29, 2012

U.S. SENATE,
SUBCOMMITTEE ON PRIMARY HEALTH AND AGING,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10:03 a.m. in Room 430, Dirksen Senate Office Building, Hon. Bernard Sanders, chairman of the subcommittee, presiding.

Present: Senators Sanders, Mikulski, Bingaman, and Franken.

OPENING STATEMENT OF SENATOR SANDERS

Senator SANDERS. I'm Senator Bernard Sanders, chairman of the Subcommittee on Primary Health and Aging, and the hearing that we are going to be holding today deals with an issue that, in my view, does not get the kind of attention that it needs. We talk a whole lot about the health care crisis in America and the 50 million people who have no health insurance, and the people who die because they don't get to a doctor, and the high cost of health care, and all of those issues are enormously important.

But when we talk about health care, it is also important to talk about dental care and the great crisis that we have in this country with regard to the high cost of dental care and the lack of access to dental care, and that's what the topic of this hearing is about.

So let's start off by talking about the nature of the crisis. Today in America, 130 million Americans have no dental insurance. One-quarter of adults age 65 or older have lost all of their teeth. Many of them have dentures. Some of them don't. Only 45 percent of Americans age 2 and older had a dental visit in the past 12 months, and more than 16 million low-income children go each year without seeing a dentist.

Lack of dental care, dental access, is a problem all over this country, but it is a serious, serious problem for low-income Americans, for racial or ethnic minorities, for pregnant women, for older adults, for those with special needs, and for those who live in rural communities. Simply put, which is often the case in terms of social services, the people who need the services the most are the ones who get them the least.

Over the last couple of months, I have been asking people in the State of Vermont and throughout this country to write to us, to tell us the stories of what it is like struggling without dental care. We have received over 1,200 separate stories, and you have the feeling

that people wanted to finally have an opportunity to vent, many from Vermont, but many from all over this country, and those stories are available on our Web site, www.sanders.senate.gov.

When we talk about dental care, what we should be careful in terms of understanding, we're not just talking about a pretty smile. What we're talking about is people going throughout their lives experiencing severe pain. We should be aware that a major cause of children's absenteeism from school is dental pain, toothaches. We should be aware that when we talk about dental problems, we're really talking about health problems, because if your teeth are in bad shape, you're not chewing your food properly, you're going to have nutritional problems, you can have higher risk of diabetes, heart disease, digestive problems, and poor birth outcomes. And as I think Senator Mikulski will talk about in a moment, you can talk about death. People have died when they have serious and neglected tooth problems.

What we also have to understand is that if we are going to address the dental crisis in this country, in my view Congress is going to have to act, and it's going to have to act boldly. Let me just talk about some of the problems out there in terms of how we do dental care.

First, we need more dental providers. Simply stated, we don't have enough dental providers. We are seeing more dentists retire than we are seeing younger dentists graduate from dental school. But even that is only half of the problem, because you can have more dentists, but those dentists are not going to the areas where we need them the most. Most dental practices are in middle class, upper middle-class neighborhoods, not in the areas where we need them the most.

So we have to be thinking about expanding the dental workforce above and beyond just dentists. I know that we have some of the panelists who will be talking about the proper role that folks like dental therapists can be playing.

Second, we have to understand that only—and this is a very important fact—only 20 percent of the Nation's practicing dentists provide care to people with Medicaid. Most dentists do not take Medicaid or only take a few Medicaid patients, and only an extremely small percentage devote a substantial part of their practice to caring for those who are under-served.

So it's not simply a question of bringing in more dentists if those dentists are not going to treat the people who need dental care the most.

Third, we need to expand Medicaid and other dental insurance coverage. One-third of Americans do not have dental coverage. Traditional Medicare does not cover dental services for the elderly, and States can choose whether their Medicaid programs provide coverage for dental care for lower-income adults. Children with Medicaid or CHIP are required to have coverage for dental services, but insurance alone does not guarantee access. Only 38 percent of kids with Medicaid in the United States see a dentist during a year.

Now, I've given you some bad news. Let me give you some good news. Then we're going to hear a little bit about that today. I happen to believe that one of the ways that we can make progress in gaining access for dental care for low- and moderate-income people

is through the expansion of community health centers, and that is something that Senator Mikulski and I and others work very, very hard on.

In my State of Vermont, in the last 5 or 6 years, we have significantly expanded dental access by opening up beautiful clinics, state-of-the-art clinics all over the State of Vermont, and now we have a situation where almost 25,000 people in the State of Vermont are getting their dental care through community health centers, and these community health centers are providing wonderful care in beautiful, new facilities. So in Vermont we are making some progress. I think that progress is taking place around the rest of the country, but we'll want to discuss that issue in greater depth in a little while.

I'd like to now give the microphone over to Senator Mikulski, who has been interested in the issue of dental care and health care for many, many years.

Senator Mikulski, thanks for being with us.

STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. Thank you very much, Mr. Chairman. I'm going to thank you for holding this very important hearing on oral health and seeing it as part of primary care. Your own commitment and vigor in ensuring universal health care for all Americans is well-known, well-appreciated by many of us, and we can't do a lot of this without you.

I come to this subcommittee not only as a member of yours but as someone who chairs the Subcommittee on Children and Youth. And a particular and unique need is the access to dentists for children, and also those children with very special needs that need unique ways of delivering dental care.

We in Maryland, Senator Cardin and myself, feel a very poignant and compelling responsibility in this area because 5 years ago a little boy named Deamonte Driver, living in Prince George's County, within the shadow of the capital of the United States, died because of an infection that he incurred because of the failure to have access to timely dental care, and also to generalized health care. We couldn't believe it. We couldn't believe that in the United States of America, a little boy, a little boy would die because he couldn't have access to a doctor, and it wasn't a rare doctor. It wasn't a doctor with—it wasn't neurology. It was dentistry.

And at that time we were debating the SCHIP, and we made a commitment, and with the help of great colleagues like Senator Sanders, we went to work to make sure that dental care was included.

The legacy of Deamonte continues to be with us, and we feel the best way to honor that little boy's memory is to continue to fight so that no little boy, no child in America goes without universal health care and goes without access to dental care.

Senator Sanders last week had an excellent hearing in Maryland chaired by our dear colleague, Congressman Cummings, in which we examined some of the issues and the progress made. We were pleased that Dr. Edelstein and Shelly Gehshan was there at that time. We looked over many of the points that were covered because we said in those 5 years, how has the situation improved, has it

improved at all, and how can we improve access and improve the delivery systems? Because we don't want access to be a hollow opportunity.

Often when we provide access, we wanted to be sure that we looked to what did the dentists say their handicaps are in providing care. We all know that the issues of reimbursement often range from skimpy to spartan. But for many of them, they say that's not the only problem. It's the failure to keep appointments. It's when they come, all of the social service needs that people come with. It's beyond the capacity of dentists who often practice all by themselves with the help of a single or two dental hygienists. So they said help us so we can get out there and help the kids.

We're proud of what we've done in SCHIP, and we're proud of new innovations and new models. We listened to new thoughts, like Dr. Kaplan, who heads up the Oral Health Impact Project, where they take dental care to students. They actually set up clinics in school auditoriums and make sure that they go to where the kids are.

But we also heard very compelling problems from a mother who was the mother of autistic twins and how she was rejected, how she was rebuffed, nobody wanted to treat these girls, and often if someone comes with a physical handicap or the challenges of intellectual disabilities or other emotional childhood diseases, it's beyond the scope often of a small dental practice to know what to do and how best to do it.

So we've got big challenges, and though we've passed SCHIP, a really big step forward, though we've passed the Affordable Care Act, another giant step forward, we have a long way to go, and I look forward to listening to the testimony today for the best ideas on how we can move ahead, and I congratulate you because in the United States of America, for all those Deamonte Drivers—you know, Mr. Chairman, had he lived, he would be getting ready to think about what school he wanted to go to. He might even be thinking about the University of Maryland and the School of Dentistry, but we'll never know. But we do know about the other children in America.

Thank you, and let's get on with it.

Senator SANDERS. Senator Mikulski, thank you very, very much.

Let's begin our panel with Dr. Burt Edelstein, who is a board-certified pediatric dentist and Professor of Dentistry and Public Health at Columbia University. Previously, Dr. Edelstein practiced pediatric dentistry in Connecticut and taught at the Harvard School of Dental Medicine for 21 years. He is the founding director of the Children's Dental Health Project, and authored the child section of the U.S. Surgeon General's Report on Oral Health in America.

Dr. Edelstein, thanks very much for being with us.

STATEMENT OF BURTON L. EDELSTEIN, D.D.S., MPH, PROFESSOR OF DENTISTRY AND HEALTH POLICY AND MANAGEMENT, COLUMBIA UNIVERSITY, NEW YORK, NY

Mr. EDELSTEIN. Thank you, Senator Sanders, and thank you, Senator Mikulski, for the opportunity to again raise this issue and to highlight what has already been accomplished and what has yet

to be done. I was kindly asked by your staff to address the problem and to describe what is known in the context of oral health disparities, dental care disparities, and the consequences of these disparities.

This hearing does address exactly what the Surgeon General called upon in identifying oral health problems as a hidden epidemic, and that Healthy People has highlighted by indicating that oral health is one of the leading health indicators in the United States. The disparities are manifest, and I thought I would summarize my written testimony by raising five questions and seeing if I can answer them in brief.

The first is, as you've already mentioned, Senator Sanders, is there, in fact, a problem? Well, yes. Reliable, objective Federal data reported by Healthy People 2020, by the Institute of Medicine, by the U.S. Surgeon General, all confirm profound disparities, as you mentioned, in relation to race, ethnicity, income, disability, education, virtually every indicator of social vulnerability.

It's a problem that's well recognized by the public, but only when the public is asked, and I thank you and congratulate you on asking the public. Generally, when asked about health issues, people don't respond about oral health unless it's prompted. But as soon as they do, oral health issues rise to the top of their concerns.

It's certainly well-known to people that work in emergency rooms, in FQHCs, in the safety net, work in dental schools, work everywhere, including now, thanks to your efforts, here on Capitol Hill.

Is the problem significant? According to relevant Federal agencies that would include CDC, NIH, IHS, HRSA, CMS, the Agency for Children and Families, Department of Agriculture with its WIC program, the problem is large, and the problem is also significant.

Which brings me to question 3: Does it matter? If it really didn't matter, then there wouldn't be reason for this hearing, there wouldn't be reason to take action. But the mouth is an essential body organ, essential to eating, breathing, communicating, sensing and protecting our bodies. It has specialized tissues, and when they're not healthy, the impact is both immediate in pain and infection and chronic in the exacerbation of medical conditions, as you've mentioned.

Oral diseases impact function, appearance, employability, school performance, and even military readiness. It stresses families and it presses community services, and on this anniversary of Deamonte's death—thank you for putting us in that context, Senator Mikulski—it certainly does drive home the point that it can have even dire consequences.

But let's get to the two more important questions. Is it fixable? And what is the role of the Federal Government?

Is it fixable? Yes. Fixing the problem of disparities is complex. It's complex because it involves both the delivery system and the people who utilize that system. It involves workforce public and private systems, research and demonstrations, prevention, alignment of incentives, public education. It involves a host of issues. And I am so pleased to report, with clarity, that the U.S. Congress has taken action to put each of these elements into an orderly, sensible, reasoned and carefully developed set of policies that exist

across Federal legislation, particularly in the CHIP reauthorization of 2009 and in the Affordable Care Act of 2010.

Taken together, the nearly two dozen provisions that are in those two laws bring us to what one person has characterized as getting us to third base. We are almost home, but we're not the rest of the way home because those authorizations become meaningless until appropriations and enactment and appropriate regulatory action and congressional oversight take us the rest of the way.

I'm pleased to say that while the problems are complex in that they involve both the consumer and the delivery system, that has been carefully analyzed over a long period of time, by this committee in particular, by the HELP Committee and by the Finance Committee in the Senate, by the comparable and appropriate committees in the House, and those laws now provide an exquisite framework for addressing solutions to the problem.

So what is the Federal role? The Federal role is powerful because it involves not only authorization and then moving that authorization, but there are provisions that are direct from the Federal Government, the FQHC programs, Head Start programs, WIC programs. There are programs that are less direct but have a Federal role, workforce training, support of research into best practices so that we prevent the diseases we're talking about, because we cannot drill and fill our way out of these problems—public education campaigns, oral disease surveillance—but most important of all is coverage.

Now, while Congress has ignored coverage for adults—Medicare doesn't include it, Medicaid barely covers it, it certainly leaves it up to State option, and ACA ignores it—Congress has been terrific on attending to children's coverage. As of the passage of ACA, combined with CHIPRA and Medicaid, virtually every child in America will have access to dental coverage. Now the question is how do we move the other pieces of the puzzle so that that coverage translates into prevention, disease management to really limit the disease burden, and then subsequently into actual services for those children.

I look forward to your questions and I hope that we can focus particularly on what Congress has already done and how that sets the stage for what has yet to be done. Thank you.

[The prepared statement of Mr. Edelstein follows:]

PREPARED STATEMENT OF BURTON L. EDELSTEIN, D.D.S., MPH

Senator Sanders, Senator Paul, and members of the subcommittee. Good Morning. I am Dr. Burton Edelstein, professor of dentistry and health policy at Columbia University and founding president of the Children's Dental Health Project (CDHP), a DC-based independent non-profit organization committed to eliminating disparities and achieving equity in oral health.

In these professional roles and in my role as a commissioner of the Medicaid and CHIP Payment and Access Commission, I seek to objectively analyze and understand the oral health disparities, the dental care disparities, and the consequences of these disparities that your hearing today addresses. I thank you for your concern over what Surgeon General Satcher described as a "hidden epidemic" of oral disease and what Healthy People 2020 has identified as a "leading health indicator" for the Nation.

According to Healthy People 2020 (<http://healthypeople.gov/2020/LHI/oralHealth.aspx>) there are ongoing, impactful, and addressable oral health disparities at all ages that require the Nation's attention in order for the U.S. population to enjoy better oral health and associated general health. Among these are:

- population-wide inadequate use of dental services with fewer than half of all Americans obtaining dental care in a year.
- disparities in dental care by race, ethnicity, income, educational attainment, and disability status.
- disparities in dental care by insurance-coverage with more privately insured people than publicly insured or uninsured obtaining care in a year.
- disparities in dental care by place with people living in cities and suburbs having more care than those in rural areas.

In and of themselves, these disparities would not be of concern to Congress were it not that people with characteristics associated with these disparities—minority status, low income and education, disability, public insurance or no insurance, and rural residence—also have higher rates of oral diseases and that oral diseases are impactful on people’s ability to, in the words of Healthy People 2020, “speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions.” Oral diseases cited by Healthy People 2020 include dental caries, periodontal disease, congenital malformations like cleft lip and palate, oral and facial pain disorders, and oral and pharyngeal cancers. Importantly, most of these conditions and their significant consequences in pain and dysfunction are preventable and prevention requires use of dental services.

The Medicaid and CHIP Payment and Access Commission employs a schema to understand and investigate access to health care. This model has two parts: (1) the availability of services to answer the question, “Are healthcare facilities and providers available?” and (2) the use of services to answer the question, “Do people use services when they are available?” This formulation recognizes the complexity of understanding access issues like dental care because it incorporates both concerns about providers of health care and concerns about consumers of health care.

The issues surrounding access to healthcare are many and complex, including myriad considerations of workforce—its adequacy, competency, makeup, distribution, and integration; delivery systems—both safety net and private; and coverage and financing—employer sponsored, individual market, Medicare, Medicaid, and CHIP. These are as true for dental care as other health services. I wish to focus particularly on coverage issues today as coverage is a significant driver of access and contributes to shaping workforce and delivery systems. Coverage issues apply equally to care accessed in the private sector as in the safety net, including the growing network of Federally Qualified Health Centers (FQHCs) that offer dental services.

Medical and dental coverage are inherently different in design, availability, and use. Nonetheless, dental coverage is an overwhelmingly significant component of access to care, particularly for Americans of modest or low incomes. I cannot stress enough that Congress, in its decisions about coverage, has only very recently recognized that dental services are essential to basic, primary, health care—and then only for children.

The record is clear that Congress considers dental care to be an “optional” service for adults. For adults, it is missing in Medicare, largely absent in Medicaid, and unaddressed in health reform.

- As a result of the Medicare exclusion of dental coverage, millions of baby boomers will be moving out of employer-sponsored dental coverage that they have enjoyed for decades and into no dental coverage at all. Unlike many of their predecessors, they have benefited from dental care and have retained their teeth. They will need ongoing and regular basic primary dental care which is increasingly priced out of reach for the uninsured.

- As a result of Congress determining in Medicaid that dental care is “optional”, it is up to the States to elect adult dental coverage. According to tracking data from the American Dental Association, in 2009 23 States limited their coverage only to emergency relief of pain and infection (n = 16) or offered no dental coverage at all (n = 7). Since that time, additional States have cut adult dental programs as a cost savings measure. The outcome is that pregnant women, the disabled, those in long-term care, and other very vulnerable individuals that rely on Medicaid for their medical care have very limited access, if any, to dental care.

- Now as States set up coverage expansion through health reform, Congress has obligated them to cover only pediatric dental care, again ignoring the importance of oral health to adults, including the most vulnerable.

This consistent record of exclusion is equivalent to arbitrarily excluding a limb, an organ, or an essential biological function from health coverage. It inherently suggests that dental care is not primary care, not essential care, and something that people can do without.

In sharp contrast to Congress' approach to adults, it has increasingly recognized the importance of dental care for children. I applaud Congress for its passage of historic policies that not only assure that children have extensive access to coverage but that go further by addressing prevention, public education, workforce, training, early intervention, research, quality, and accountability. It is my sincere hope that your subcommittee's work serves to further catalyze Congress—as well as the State and Federal Governments—in assuring that oral health provisions in existing law (e.g. the Safety Net Improvement Act of 2002, the Children's Health Insurance Program Reauthorization Act of 2009, and the Affordable Care Act of 2010) are moved from congressional intent to meaningful care for America's children.

Since the original enactment of S-CHIP in 1997, our Country has made meaningful strides in ensuring that oral health is attended to for children in Federal health programs. Head Start and WIC are attending to children's oral health. Multiple Federal agencies have active pediatric oral health initiatives. Countless reports, including many by the Government Accountability Office at congressional request and others by the Institute of Medicine have been published. A number of congressional hearings have been held, dozens of bills introduced, and key legislation enacted. Many States have similarly undertaken notable oral health initiatives.

Sadly, the catalytic tragic event that awakened many policymakers to the seriousness of poor oral health was the death of 12-year-old Deamonte Driver 5 years ago this week. In fact, the day Deamonte's death was reported in the *Washington Post*, the Children's Dental Health Project was attending a long scheduled meeting with the Senate Finance Committee. The purpose of our meeting was to ask the committee to support inclusion of a mandatory dental benefit in the CHIP reauthorization. Our efforts to date had not resonated but that morning, the tragedy of this child's death transformed our conversations with policymakers forever. It became painfully clear what had long been known and well-documented but not fully recognized in policy: that oral health is essential to overall health and that poor oral health has significant and yes, sometimes tragic, consequences on our health and well-being.

Just a few weeks after that conversation, the Senate Finance Committee accepted a bipartisan amendment to add a dental benefit to the reauthorization of CHIP. Today, all 50 States are required to offer dental benefits to children enrolled in Medicaid and CHIP and States are now planning the provision of dental care for children through their Exchanges. The question now is, what needs to be done to make these provisions real for families across the country?

At this point, it is critical that the provisions of CHIPRA and ACA are implemented effectively and that States have the appropriate guidance and flexibility to create a coordinated health care system that truly incorporates oral health care. Continued congressional interest and oversight is required to ensure that these laws' common sense provisions are maximally implemented as, together, they inform the public about risks for oral disease in children, provide targeted and timely information to new parents, advance the science of disease management, enhance training for dentists and dental hygienists, promote accountability through disease surveillance, and encourage the piloting of creative new workforce models including a new paraprofessional concept built on principles of social work—the Community Dental Health Coordinator, as proposed by the American Dental Association.

Let me highlight two of these many opportunities that focus on advancing oral health through cost-effective prevention:

- ACA establishes a National Oral Health Literacy Campaign that can raise public awareness about prevention and encourage appropriate use of dental services. Recognizing current budget constraints, we encourage that this campaign, authorized at \$100 million, be initiated with a \$5 million investment in Federal fiscal year 2013.

- The CDC is primed to address the very high rates of ordinary tooth decay in America's youngest children. CDC reports that more than 1 in 10 2-year olds, 2 in 10 3-year olds, 3 in 10 4-year olds, and 4 in 10 5-year olds has visible cavities and that three-quarters of affected children are in need of dental repair. The Surgeon General reports that these rates are five-times greater than childhood asthma, the next most prevalent chronic disease of U.S. children. Because prevention is cost savings and improves quality of life, we encourage support for \$8 million in expanded funding in fiscal year 2013 to support CDC demonstrations of early childhood caries prevention and management.

Arguably, the most important of CHIPRA and ACA dental provisions are the requirements that States cover pediatric oral health care. Regulatory guidance is needed to assure that dental coverage established by CHIPRA meets covered children's needs and that the CHIPRA dental benefit can serve well as a benchmark

for the pediatric dental benefit in ACA. ACA appropriately establishes pediatric dental care among the 10 Essential Health Benefits that must be covered. As you are well aware, however, there is a heated debate at both the Federal and State levels about how these benefits should be defined, how they will be accessed in the State Exchanges, and how consumer protections will apply. Because these critical issues are particularly nuanced for dental coverage, it is important that the details be attended to with care. I urge you to look closely at these technical issues as their resolution will determine how meaningful the dental benefit will be to children and their families and how they will contribute to access.

To address the problem of inequitable access through coverage reform, it is critical that every dental plan certified by the State or Federal Exchanges requires the same substantive level of consumer protections. Whether dental coverage is obtained through a qualified health plan or a limited-benefit stand-alone dental plan, consumers need to be assured of choice, affordability, network adequacy, and quality. Exemption of these requirements for dental plans but not qualified health plans would be at the expense of children and their parents. Congressional intention needs to be clearly communicated to State legislatures and Exchange Boards as they establish their own policies. An amendment by Senator Stabenow adopted by the Senate Finance Committee clarified that intention. It stated that “. . . standalone dental plans must . . . comply with any relevant consumer protections required for participation in the Exchange.” This language was reiterated in a September 22, 2011 colloquy with Senators Baucus and Bingaman when Senator Stabenow stated,

“I intended for standalone dental plans to fully comply with the same level of relevant consumer protections that are required of qualified health plans with respect to this essential benefit.”

The dental benefits created by CHIPRA and ACA must also be designed to respect differences among our Nation’s children in their level of risk for tooth decay. We encourage Federal and State policymakers to adopt best practices in coverage and care as suggested by the American Academy of Pediatric Dentistry (AAPD). AAPD calls for “risk-based” care that provides the most intensive clinical care to children with the greatest level of disease and risk for ongoing disease. A pediatric-only dental benefit should follow AAPD’s guidance and thereby promote allocation of care according to individual children’s needs. By preventing dental disease at an early age and managing the disease as a chronic condition when it does occur, we can significantly reduce the cost of care and improve the quality of life for our children while setting them on a path toward lifetime oral health.

Many of you and your colleagues have a long history of extraordinary leadership in the Congress on health issues. On behalf of children who do have coverage through your actions, advocates and families now look to you for follow through on CHIPRA and ACA that will assure full implementation of the oral health provisions. Doing so will save money, improve patient experience, and improve the Nation’s oral health. There is much yet to be done and we look forward to working with you to reach the goal of equitable oral health and dental care for all.

That concludes my testimony. I am happy to answer any questions you may have. Thank you.

Senator SANDERS. Dr. Edelstein, thanks very much.

Our second witness is Shelly Gehshan, director of the Pew Children’s Dental Campaign at Pew Center on the States. Last year she served on the Institute of Medicine’s Committee on Oral Health Access to Services, which made recommendations for how the United States could improve access to dental care.

Prior to joining Pew, she spent nearly 20 years working for State policymakers, including work as a senior program director at the National Academy for State Health Policy.

Ms. Gehshan, thanks very much for being with us.

STATEMENT OF SHELLY GEHSAN, MMP, DIRECTOR, PEW CHILDREN’S DENTAL CAMPAIGN, PEW CENTER ON THE STATES, WASHINGTON, DC

Ms. GEHSAN. You’re welcome. Thank you, Mr. Chairman, and thank you, Senator Mikulski, for inviting me here today to testify, and thank you both for your leadership on oral health issues.

My name is Shelly Gehshan. I am the director of the Pew Children's Dental Campaign, and we released a big report yesterday. I'd like to start with talking about that, and then talk a little bit about the Institute of Medicine panel that I served on last year.

Numerous reports have found limited access to dental care, so if you ever hear otherwise, we have a wealth of data that asserts and describes the problem that we are discussing here today.

We released a Costly Dental Destination yesterday that documents the problem of people showing up in emergency rooms for dental care. It is a symptom of a failing system, and it is a huge waste of money. And although there have been many State reports, no one has ever collected them all together, and this was the first time that national data was made available on that issue.

The report estimates that in 2009, there were more than 830,000 ER visits nationwide, which is a 16 percent increase over 2006. So we're going in the wrong direction. These are the wrong services in the wrong setting at the wrong time for desperate people who have no other alternative. We can really do a better job than this. There are a number of State examples I'm happy to describe later if there's time.

The Institute of Medicine looked at this quiet crisis in access to dental care for about a year, and we issued a report last July, and I'm going to describe several of the 10 recommendations that the IOM made.

The first one I'd like to describe is prevention, because these are largely preventable problems, and that's the cheapest and most humane way to attack the issue. Sealants and water fluoridation are key, but in 23 States sealant programs reached less than a quarter of high-risk children, and we have 74 million people in this country who don't have access to fluoridated water, more if you count those who have well water.

The IOM committee recommends that Congress ensure that all 50 States receive infrastructure funding so that they can mount effective, proven prevention efforts in their States. The IOM also recommended that the Title 5 Maternal and Child Health Block Grant be used to augment that funding and ensure that all States have infrastructure.

On financing, as Burt mentioned, access to care is greatly dependent on the ability to pay, and way too few people have dental coverage. Since States are not required to provide dental coverage for adults, most do not. It ebbs and flows over time based on the economy, but that's a big driver for what makes people end up in emergency rooms to begin with, is that they have no way to pay for care. If they had a dentist, they'd go to one, but no one will accept them.

The Institute of Medicine recommended that Congress move toward expanding dental benefits to all Medicaid beneficiaries, as well as ensuring that Medicaid reimbursement rates are higher than they are now, and that administrative processes be streamlined.

The IOM also recommended several strategies to expand access to dental care at community health centers, which form the backbone of the safety net in this country, including ensuring that they can use a broader array of providers than they have now, and that

there's money available from Congress to both recruit and retain providers.

And then finally the IOM addressed the issue of workforce shortages, because we have got to do something about workforce shortages. Forty-seven million Americans live in areas that are federally designated as having a shortage of dentists, and at this point more than a dozen States are looking at developing new types of providers to expand the dental team and work under the supervision of a dentist to reach more people, because roughly we have about a third of the population left outside of the current system, and that's just too many.

In terms of the new types of providers, there are dental therapists who have worked effectively in other countries for years. There are also approaches where States would add training for dental hygienists or dental assistants or health workers.

The IOM examined all studies done of alternative practitioners, both in this country and abroad, and looked also at the issue of whether or not they could safely provide restorative care or drilling and filling cavities, and concluded that all available evidence points to the safety and quality of these providers being allowed to join the dental team.

So the IOM recommended that Congress, foundations, and the Federal Government research how to use them to expand access, and urged Federal funding to support demonstration projects to study how those providers would be used to reach people who are left outside the system now.

So to conclude, I think my two points would be I think it's really critical for Congress to ensure that all States have infrastructure funding to mount prevention efforts, and that Congress pay more attention to innovations that are necessary.

In all my years in Washington and all the issues that I have worked on, I have never been in a field with fewer consumer choices and less innovation. There's just not much known about how to do a better job of reaching people left outside the system.

So thank you very much, and I look forward to answering any questions you may have.

[The prepared statement of Ms. Gehshan follows:]

PREPARED STATEMENT OF SHELLY GEHSAN

Mr. Chairman, Ranking Member Paul, and members of the committee, thank you for holding this hearing and for the opportunity to testify. My name is Shelly Gehshan, and I am the director of the Pew Center on the States' Children's Dental Campaign. I am pleased to join my colleagues in appearing before you today. The Pew Children's Dental Campaign works to improve children's dental health through advocating for more prevention, adequate funding for care, and ensuring there is a sufficient workforce to care for low-income children.

ACCESS TO DENTAL CARE

Numerous reports have found that limited access to dental care is a growing problem nationwide. I will focus today on two such reports: an issue brief the Pew Center on the States released yesterday on wasteful spending on dental care in emergency rooms, and a report outlining the recommendations of the 2011 Institute of Medicine panel on how to improve access.

In 2009, the last year for which complete data are available, more than 16 million American children went without dental care.¹ There are several factors contributing to this access crisis, such as lack of insurance and inability to pay, and geographic and transportation barriers in rural areas. Furthermore, about 47.8 million Americans live in areas federally designated as having a shortage of dentists.² Many families face another kind of shortage, as they struggle to find dentists who participate in the Medicaid program. Fewer than half of the dentists in 25 States treated any Medicaid patients in 2008.³

This access problem has serious consequences. For example, research from California and North Carolina shows a clear link between poor oral health and students' ability to attend school and perform well.⁴ In California alone, more than 500,000 children were absent at least one school day in 2007 due to a toothache or other dental problem.⁵

HOSPITAL ER ADMISSIONS RELATED TO DENTAL CARE

This lack of access to dental care has led to more and more people entering hospital emergency rooms (ERs) with preventable dental conditions. The brief the Pew Center on the States issued yesterday, "A Costly Dental Destination,"⁶ estimates that in 2009, preventable dental conditions were the primary diagnosis in more than 830,000 visits to ERs nationwide, a 16 percent increase from 2006.⁷ These ER admissions impose a significant and unnecessary burden on State budgets. A 2006 national study found that treatment during 330,000 decay-related ER visits cost nearly \$110 million.⁸ Furthermore, hospitals are generally unable to treat conditions such as dental abscesses and toothaches, as few ERs have dentists on staff or clinicians who have the training to treat the underlying issues.⁹ Many patients who leave without the underlying dental problem addressed often return to the ER later as their condition deteriorates, for care costing far more than services provided in a dental office or clinic.

¹U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Medicaid Early & Periodic Screening & Diagnostic Treatment Benefit—State Agency Responsibilities" (CMS-416), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/2009-National-Data.pdf> (accessed February 27, 2012). This figure counts children age 1 to 19. Data from the 48 reporting States and the District of Columbia were supplemented with reports obtained directly from Michigan and Oregon.

²U.S. Department of Health and Human Services, Health Resources and Services Administration, Designated HPSA Statistics Report, "Health Professional Shortage Areas by State," February 24, 2012, http://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry&rs:Format=HTML3.2 (accessed February 27, 2012).

³U.S. Government Accountability Office, "Efforts Under Way to Improve Children's Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns" (November 2010), <http://www.gao.gov/new.items/d1196.pdf>. Note: the GAO analyzed data from 39 States.

⁴S.L. Jackson, et al., "Impact of poor oral health on children's school attendance and performance," *American Journal of Public Health* (October 2011), <http://www.ncbi.nlm.nih.gov/pubmed/21330579>.

⁵N. Pourat and G. Nicholson, *Unaffordable Dental Care is Linked to Frequent School Absences* (Los Angeles, CA: UCLA Center for Health Policy Research, 2009) 1-6, <http://www.healthpolicy.ucla.edu/pubs/publication.aspx?pubID=387> (accessed September 2, 2010).

⁶"A Costly Dental Destination: Hospital Care Means States Pay Dearly," (February 2012).

⁷Agency for Healthcare and Quality (AHRQ), "Healthcare Cost and Utilization Project (HCUP)—The nationwide Emergency Department Sample for the year 2009 and 2006." AHRQ, Rockville, MD. <http://hcupnet.ahrq.gov/> accessed February 7-8, 2012. The Pew Children's Dental Campaign identified preventable dental conditions using the International Classification of Diseases (ICD-9) codes of 521 and 522. These codes were chosen in consultation with Dr. Frank A. Catalanotto, DMD, Professor and Chair of the Department of Community Dentistry and Behavioral Science at the University of Florida's College of Dentistry. Primary diagnosis is defined as visits in which one of these codes was listed first on a patient's discharge record. One of these two ICD-9 codes was the primary code for 717,032 ER visits in 2006 and for 830,590 visits in 2009, which constituted a 15.8 percent increase over this 4-year period. These figures do not include emergency dental visits for which these codes were listed as a secondary code. One of these codes (521 and 522) were listed as either a primary or secondary code for 1,116,569 ER visits in 2006 and for 1,357,217 ER visits in 2009, which constituted a 21.6 percent increase. Secondary diagnosis codes are of interest because the first diagnosis listed for an ER visit may not always coincide with the primary or only reason why the patient was treated.

⁸Of the 330,757 ER visits for dental-related causes, 330,599 (99.9 percent) did not require a hospital stay. See: R. Nalliah, V. Allareddy, S. Elangovan, N. Karimbux, V. Allareddy, "Hospital Based Emergency Department Visits Attributed to Dental Caries in the United States in 2006," *Journal of Evidence Based Dental Practice* (2010), Volt. 10, 212-22, [http://www.jebdp.com/article/S1532-3382\(10\)00183-1/abstract](http://www.jebdp.com/article/S1532-3382(10)00183-1/abstract).

⁹P. Casamassimo, S. Thikkurissy, B. Edelstein, and E. Maiorini, "Beyond the DMFT: The Human and Economic Cost of Early Childhood Caries," *Journal of the American Dental Association* 140 (2009): 650-57.

In this brief, the Pew Center on the States examines hospital data from 24 States showing the frequency and cost of dental-related ER visits. Data on ER visits related to dental care are not available in the majority of States. While the report highlights this growing problem in States for which there are data, it significantly underestimates the nationwide scope.

In California alone, there were more than 87,000 ER visits related to preventable dental conditions in 2007,¹⁰ and Maine data from 2006 show that dental problems were the leading reason why Medicaid enrollees and uninsured young people visited the ER that year.¹¹

INSTITUTE OF MEDICINE RECOMMENDATIONS ON IMPROVING ACCESS TO CARE

Persistent lack of access also led the Institute of Medicine (IOM) to study the issue and release its recommendations last year. I had the privilege to serve on the IOM's Committee on Oral Health Access to Services, and I am pleased to share the recommendations with you today. Included in all of these recommendations are the cost-effective and research-based approaches identified in the Pew issue brief as ways to prevent dental-related ER visits.

PREVENTION

Prevention is the most cost-effective way to improve dental health. Recognizing this, the committee recommended that the Centers for Disease Control and Prevention (CDC) and the Maternal and Child Health Bureau (MCHB) collaborate with States to ensure that they have the infrastructure and support necessary to perform core dental public health functions.¹² This infrastructure is critical for States to implement evidence-based prevention programs.

We have a long way to go to ensure these essential dental public health programs reach those who need them. Dental sealants—clear plastic coatings that are applied to molars—have been proven to prevent 60 percent of tooth decay at less than one-third the cost of filling a cavity.¹³ Yet, in the 2009–10 school year, sealant programs reached fewer than one-quarter of the highest-need schools in 23 States. In addition, seven States had no school-based sealant programs at all.¹⁴ Community water fluoridation reduces decay rates for children and adults by between 18 and 40 percent, and for most cities every dollar invested in fluoridation saves \$38 in dental treatment costs.¹⁵ However, the most recent Federal data show that more than 74 million Americans on public water systems lack access to fluoridated water.¹⁶

Currently, only 20 States receive CDC infrastructure grants, but those that do have been able to strengthen oral health programs, collect crucial data on the scope of their challenges, and implement prevention activities.¹⁷ These relatively small, cost-effective investments have the potential to improve the dental health of communities, improve access to care, and reduce decay—and therefore, costs. These grants are needed in all 50 States.¹⁸

The IOM committee also recommended that the MCHB use the title V program to provide block grants and other funding for oral health. We also recommended

¹⁰ California HealthCare Foundation, “Emergency Department Visits for Preventable Dental Conditions in California,” (2009), accessed October 13, 2011, <http://www.chcf.org/media/MEDIA%20LIBRARY%20Files/PDF/E/PDF%20EDUseDentalConditions.pdf>.

¹¹ B. Kilbreth, B. Shaw, D. Westcott, and C. Gray, “Analysis of Emergency Department Use in Maine,” Muskie School of Public Service, (January 2010), accessed October 3, 2011, <http://muskie.usm.maine.edu/Publications/PHHP/Maine-Emergency-Department-Use.pdf>.

¹² Institute of Medicine. *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*, 14 (July 2011).

¹³ Recommendations on Selected Interventions to Prevent Dental Caries, Oral and Pharyngeal Cancers, and Sports-Related Craniofacial Injuries,” Centers for Disease Control and Prevention Task Force on Community Preventive Services, *Am J Prev Med* 2002;23(1S), <http://www.thecommunityguide.org/oral/oral-ajpm-recs.pdf>; American Dental Association. 2011 Survey of Dental Fees. (2011), 17. National median charge among general practice dentists for procedure D1351 (dental sealant) is \$45 and national mean charge for procedure D2150 (two-surface amalgam filling) is \$144.

¹⁴ “Making Coverage Matter,” Pew Center on the States (May 2011), 8.

¹⁵ “Cost savings of Community Water Fluoridation,” U.S. Centers for Disease Control and Prevention, accessed March 30, 2011 at http://www.cdc.gov/fluoridation/fact_sheets/cost.htm.

¹⁶ Centers for Disease Control and Prevention, “2008 Water Fluoridation Statistics,” (October 2010), accessed December 9, 2010, <http://www.cdc.gov/fluoridation/statistics/2008stats.htm>.16.

¹⁷ Centers for Disease Control and Prevention, “CDC-Funded States: Cooperative Agreements, September 20, 2011”, http://www.cdc.gov/oralhealth/state_programs/cooperative_agreements/index.htm, accessed February 24, 2012.

¹⁸ Institute of Medicine. *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*, 14 (July 2011).

that private foundations and public agencies collaborate on public education and oral health literacy campaigns focused on prevention.¹⁹

FINANCING OF THE ORAL HEALTHCARE SYSTEM

Access to care is greatly dependent on ability to pay for services, and individuals and families with inadequate insurance or no coverage at all are those most likely to end up in the ER with dental problems. While all States must provide comprehensive dental benefits to children enrolled in the Medicaid program, there is no requirement for adult dental coverage. Many State Medicaid programs that do cover adults only do so for emergency situations.²⁰

In the IOM report, the committee recommended that the country move toward including dental benefits for *all* Medicaid recipients. As a first step, the IOM recommended that an essential dental benefits package for adults in Medicaid be defined. Second, the IOM recommended that the Centers for Medicare and Medicaid Services (CMS) fund State demonstration projects that help us determine the best way to provide oral health benefits within the Medicaid program.²¹

To address the severe shortage of dentists accepting Medicaid, the IOM committee recommended not only raising Medicaid reimbursement rates for oral health services, but also reducing administrative barriers and providing case-management assistance.²²

Recognizing States' difficulty administering Medicaid dental programs, the IOM suggested that Congress provide enhanced Medicaid matching funds tied to efforts to reduce administrative barriers and increase provider participation in State programs.²³

IMPROVING ACCESS THROUGH THE DENTAL EDUCATION SYSTEM

A key component to improving access to dental care is the education of dentists. Recognizing this, the IOM committee recommended that dental schools:

- recruit more students from underrepresented minority, lower-income and rural populations;
- require all dental students to participate in community-based rotations; and
- recruit faculty who have experience with underserved populations.²⁴

To support these improvements, the IOM committee recommended that the Health Resources and Services Administration (HRSA) use title VII funds to expand community-based rotations for dental students, and that State legislatures require at least 1 year of dental residency before permitting a dentist to practice.²⁵

INTEGRATION OF THE MEDICAL AND DENTAL COMMUNITIES

There is a disconnect between dental health and overall health, so the IOM made a recommendation to greatly enlarge the circle of providers and find more opportunities to implement prevention strategies. The IOM committee recommended that HRSA convene key stakeholders to develop a core set of oral health competencies for nondental health care professionals to be incorporated into medical education programs.²⁶ These core competencies would prepare them to recognize the risk for oral disease, provide information and education on oral health to patients, and make and track referrals to dental health professionals. For example, education programs could include training for obstetricians and gynecologists on oral health education and prevention, or educate nurses and nurses' aides to provide preventive services in nursing homes.²⁷

IMPROVEMENTS TO THE DENTAL WORKFORCE

Finally, there is a severe nationwide shortage, as well as a geographic maldistribution, of dentists. Approximately 47.8 million Americans live in areas federally designated as dental health professional shortage areas.²⁸ The IOM made a

¹⁹ *Ibid.*

²⁰ *Ibid.*, 10.

²¹ *Ibid.*, 11.

²² *Ibid.*

²³ *Ibid.*, 12.

²⁴ *Ibid.*, 8.

²⁵ *Ibid.*, 9–10.

²⁶ *Ibid.*, 5.

²⁷ *Ibid.*

²⁸ As of February 24, 2012, those 47.8 million Americans lived in one of 4,461 dental health professional shortage areas. See "Shortage Designation: U.S. Department of Health and Human Services, Health Resources and Services Administration, Designated HPSA Statistics Report,

number of recommendations to expand the number of dental providers, and better use existing providers.

First, the IOM recommended that States amend their dental practice acts to use dental auxiliaries to the full extent of their training, and work in a wider variety of settings, using technology to foster supervision.²⁹

Second, the IOM committee reviewed all available studies about new types of providers and found no quality or safety concerns. The IOM recommended that Congress, HRSA and other Federal agencies, and private foundations conduct research to demonstrate how best to use new types of dental providers to expand access—as well as how to measure quality and access, and how to pay for performance. About a dozen States are considering authorizing new types of dental practitioners to work in underserved communities. Some of these practitioners are modeled after dental therapists who have worked effectively for decades in countries such as Great Britain, Canada, and New Zealand. Some would play a role similar to that of nurse practitioners in the medical field. Another approach is to train and license dental hygienists or assistants to provide more services than they now can provide to patients. An evaluation of dental therapists in Alaska found they were providing safe, competent care that received high ratings of patient satisfaction.³⁰

Additionally, Federally Qualified Health Centers (FQHCs) play a critical role in providing health care, including preventive dental services, to vulnerable and underserved patients. These health centers provided dental services to more than 3.7 million patients in 2010.³¹ However, taken together, the safety net only reaches 7 or 8 million of the more than 80 million who are underserved for dental care.³² The IOM committee recommended that HRSA take several steps to expand access to dental care at FQHCs. These include: developing a set of best practices being employed by certain health centers that can be replicated in other States; supporting the use of a variety of dental providers; providing services outside the clinic at community settings; and providing additional funding to recruit and retain providers.³³

Lack of access to dental care has a pronounced impact on overall health, and it is critical that we provide funding for States to establish and maintain the infrastructure necessary for prevention and comprehensive dental services. Innovation is also crucial to addressing the dental workforce shortage, and steps must be taken to increase the number and types of practitioners in underserved communities.

Thank you again for recognizing the importance of improving dental health and increasing access to care. We appreciate the opportunity to testify.

Senator SANDERS. Ms. Gehshan, thanks very much.

Our third witness is Grant Whitmer. Grant is the executive director of the Community Health Centers of the Rutland Region, based in Rutland, VT. Mr. Whitmer has worked in various in-patient and out-patient positions in the health care field over the last 30 years as both a clinician and administrator. In his current role, he oversees six medical facilities and one 8-chair dental facility. He also serves on the Vermont Medicaid Advisory Board and the Board of Bi-State Primary Care Association.

Mr. Whitmer, thanks very much for being with us.

STATEMENT OF GRANT WHITMER, MSM, EXECUTIVE DIRECTOR, COMMUNITY HEALTH CENTERS OF THE RUTLAND REGION, RUTLAND, VT

Mr. WHITMER. Good morning. I'd first like to thank Chairman Sanders and Ranking Member Paul and members of the sub-

²⁸ "Health Professional Shortage Areas by State," February 24, 2012, http://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry&rs:Format=HTML 3.2. (accessed February 27, 2012).

²⁹ Institute of Medicine. *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*, 6 (July 2011).

³⁰ *Ibid.*, 12.

³¹ Health Resources and Services Administration, "2010 National Report," pg. 49 accessed December 12, 2011, http://bphc.hrsa.gov/uds/doc/2010/National_Universal.pdf.

³² Bailit, H., T. Beazoglou, N. Demby, J. McFarland, P. Robinson, and R. Weaver. (2006) "Dental safety net: Current capacity and potential for expansion" *Journal of the American Dental Association* 137 (6): 807–15.

³³ Institute of Medicine. *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*, 15 (July 2011).

committee for highlighting the serious dental access challenges we're facing and for inviting me to share experiences about how my board and my health center are working hard to improve dental access in our communities. My name is Grant Whitmer and I've worked in the health care field for 30 years. I served as the executive director of Community Health Centers of the Rutland Region since 2006 when we became a Federally Qualified Health Center. Currently, CHCRR operates six medical facilities where we provide medical care to over 35,000 Vermonters annually. CHCRR also operates an 8-chair dental facility which provides comprehensive preventive and restorative oral health services, and where we will provide approximately 12,000 dental visits to roughly 4,000 individual patients this year.

Like other Federally Qualified Health Centers, our patients are largely low-income and experience problems with access. This is clearly reflected in our dental payer mix, which is comprised of 47 percent Medicare, 44 percent uninsured, and just 9 percent private insurance. That's 91 percent of our patients are either covered by Medicaid or have no dental insurance.

While primary medical care is central to our mission and represents the bulk of services we provide, there is an increasing body of evidence that highlights the significant impact of oral health on a patient's overall health and links to other serious healthcare conditions such as heart disease, arteriosclerosis, diabetes, poor nutrition, et cetera.

Dental care and equipment are a costly investment for a health center. We do it because there's such a significant need, it improves our patients' health, and because the significant cost savings that we believe can be realized when oral health care is provided in an appropriate setting. We recently completed a study in our small community hospital that revealed that in just 1 year, over 1,100 emergency department visits were for dental pain or other dental conditions. Treatment provided during the vast majority of these visits did not treat the underlying dental condition, but instead provided only symptomatic treatment of pain, sometimes an antibiotic, and discharge advice to seek followup treatment by a dentist. Because the underlying condition is not corrected, a considerable number of these patients return multiple times to the hospital ED for treatment of the same underlying oral health condition. We are still analyzing the data, but our initial analysis highlights two interesting facts. First, it appears that adult patients covered by Medicaid are utilizing the ED because they are unable to find a dentist who accepts new adult Medicaid patients.

Second, and more surprising to us, is the fact that it also appears that a significant number of patients covered by private health insurance, but who lack dental coverage, are using the ED for dental problems. They're doing this because the cost of treatment in the ED is covered. But if they were to seek treatment at a dentist's office, they would likely be required to pay the full cost of treatment, often in advance at the time of service, due to their lack dental coverage.

This creates a perverse circumstance whereby patients are driven to utilize one of the most costly treatment venues, the hospital emergency department, for symptomatic treatment of oral health

problems, often multiple times for the same condition, instead of accessing restorative treatment in a dental office to correct the problem at significantly reduced cost.

In 2007, 1 year after becoming an FQHC, CHCRR initiated our first dental service, a small 3-chair facility utilizing donated equipment, and within the first 30 days it was operating beyond maximum capacity.

During our first 4½ years of dental operations, CHCRR has provided over 24,000 patient dental visits and over \$1 million in free and discounted dental services. In April 2011, CHCRR relocated its dental operations from the small 3-chair facility to a new, expanded 8-chair facility, and as a result, CHCRR has more than doubled our capacity, which will allow us to provide at least 12,000 dental visits to approximately 4,000 individual patients, and over \$350,000 in free and discounted dental care each year.

CHCRR is committed to working with local dentists, schools, our local community, local hospital, and the State to expand dental access and increase the number of patients in our service area who have a regular dental home and source of dental care. Further details on these efforts were included in my written testimony.

CHCRR is only one of many FQHCs in Vermont and across the country who have demonstrated similar good work in expanding access to needed dental services and improving the health of the populations we collectively serve. FQHCs are structured around an integrated medical home model and are able to orient care in a manner that is tailored and appropriate for the needs of the community and populations they serve. We believe that FQHCs are uniquely qualified and well-positioned to be a positive and useful vehicle to expand dental access in an efficient and cost-effective manner.

Again, I'd like to thank the committee for your attention to this issue and look forward to answering any of your questions.

[The prepared statement of Mr. Whitmer follows:]

PREPARED STATEMENT OF GRANT WHITMER, MSM

Good morning. I would first like to thank Chairman Sanders, Ranking Member Paul and the members of the subcommittee for highlighting the serious oral health access challenges we're facing and for inviting me to share my experiences about how my health center is working hard to improve dental access in our communities.

My name is Grant Whitmer and I have worked in the healthcare field for 30 years as a clinician and administrator in both the inpatient and outpatient setting. I have served as the executive director of Community Health Centers of the Rutland Region based in Rutland, VT since 2006 when we became a Federally Qualified Health Center. Currently CHCRR operates six medical facilities where we will provide over 110,000 medical visits to over 35,000 Vermonters in 2012. CHCRR also operates an eight-chair dental facility which provides comprehensive preventive and restorative oral health services and where we will employ three dentists and three hygienists in order to provide approximately 12,000 dental visits to almost 4,000 individual patients in 2012.

OUR NEED: THE NEED FOR DENTAL CARE IN RUTLAND

As an FQHC, CHCRR provides a full spectrum of primary care and preventive services, we see all patients regardless of their income or insurance status, and we are governed by a volunteer patient-majority board. Like other Federally Qualified Health Centers, our patients are largely low-income, many are on Medicaid or uninsured. Today in the United States, there are over three times as many individuals without dental insurance coverage compared to the number without health insurance coverage. Additionally, dental coverage plans traditionally come with significantly higher co-payment amounts (routinely 50 percent) for major dental procedures. Low-income patients even with insurance struggle to come up with required

co-payments that are routinely required to be paid prior to beginning treatment. Patients covered by Medicaid find it increasingly hard to find a provider who will accept them due to reduced reimbursement levels.

In the CHCRR service area (Rutland County, VT) according to a community needs assessment survey conducted by Rutland Regional Medical Center and the Bowse Health Trust in 2011, approximately 71 percent of practicing dentists are currently *NOT* accepting new Medicaid patients. While primary medical care is central to our mission and represents the bulk of services we provide, there is an increasing body of supporting evidence that highlights the very significant impact of oral health on a patients overall health and links to other serious healthcare conditions to such as heart disease, atherosclerosis, diabetes, poor nutrition, etc.^{1 2 3 4 5} In light of these facts it became clear to CHCRR that we needed to expand dental access within our community. We believe it keeps our patients and communities healthier, makes good sense for the health center medical home, and ultimately saves money by reducing overall healthcare expenditures. Several studies suggest that every dollar spent on oral health returns overall healthcare savings on the order of 3 to 10 times greater.

Dental care is a large investment for a health center. However, the return on investment is notable and we see the potential for enormous cost-savings to overall health care spending by providing routine dental care. One study showed that over a 3-year period, preventive dental treatment provided in an office-based setting was nearly 10 times less expensive than care provided in the ER.⁶ A patient who puts off (or who can't access) regular, preventive dental care is likely to show up in an emergency room for treatment. We have seen this in our local community hospital. We recently completed a study with our local hospital that revealed that 3.4 percent or 1,116 of approximately 33,000 total annual visits to the Emergency Department were for "dental pain" or other dental conditions. Treatment provided during the vast majority of these visits to the hospital ED did not treat the underlying dental condition, but instead provided only symptomatic treatment of pain, possibly a prescription for an antibiotic, and discharge advice to seek followup treatment by a dentist. Interestingly, since the underlying condition is not corrected, a significant number of these patients return multiple times to the hospital ED for treatment of the same underlying oral health condition. We are still analyzing the data, but our initial analysis highlights two interesting facts. First, it appears that adult patients covered by Medicaid are utilizing the ED because they are unable to find a dentist who accepts new adult Medicaid patients. Adult Medicaid reimbursement/coverage in Vermont is capped at a maximum of \$495 per year. Many of these patients have not been to a dentist in many years and have serious conditions that require extensive dental treatment, the cost of which would exceed the annual cap. Second, and more surprising to us, is the fact that it also appears that a significant number of patients covered by private health insurance, but who lack dental coverage, are using the ED for dental problems because the cost of treatment is covered by their medical insurance instead of seeking treatment at a dentists office because they would be required to pay the full cost of treatment, often in advance at the time of service because they lack dental coverage. *This creates a perverse circumstance whereby patients are driven to utilize one of the most costly treatment venues (the hospital ED) for symptomatic treatment of oral health problems (often multiple times for the same condition), instead of accessing restorative treatment in a dental office to correct the problem at significantly reduced cost.* We are currently collaborating with the hospital to develop better mechanisms to allow us to immediately see and provide restorative treatment to these dental patients who present to the ED at our new dental facility, which is just two blocks away from the hospital. Once at our dental clinic, our intake staff work with individual patients to help them identify and access available services and develop a plan to insure the patient gets the dental treatment they need. For instance, many times we find that patients who may

¹Journal of Periodontology 2 Jul 2008: 1501–02. Inflammation and Periodontal Diseases: A Reappraisal.

²American Journal of Cardiology and Journal of Periodontology July 2009. Editors' Consensus: Periodontitis and Atherosclerotic Cardiovascular Disease.

³Warner, J (2004) The Web: "Oral Health Score May Reveal Heart Risks". <http://www.mydentistusa.com/cosmetic-dentistry-articles/oral-health-score-may-reveal-heart-risks.htm>.

⁴American Academy of Periodontology The Web "Gum Disease Links to Heart Disease and Stroke" <http://www.perio.org/consumer/mbc.heart.htm>.

⁵Long, E (2006) The Web: "Make Your Toothbrush a Weapon Against Heart Disease" [online] http://www.consumer-health.com/services/cons_take58.htm.

⁶Children's Dental Health Project. "Cost Effectiveness of Preventive Dental Services." Policy Brief, February 2005, http://www.cdc.gov/oralhealth/publications/library/burdenbook/pdfs/CDHP_policy_brief.pdf, last accessed February 2012.

qualify for Medicaid have not applied because they are confused and intimidated by the application process. In these cases our staff helps these patients complete the application process and facilitates enrollment in Medicaid. Our staff also works with patients to determine eligibility for our sliding fee scale which is available to all patients with household income below 200 percent of the Federal Poverty Level. Additionally, our staff can arrange reasonable structured payment agreements which are also based on household income. We expect that by working together with the hospital, we will be able to significantly reduce the current use of the hospital ED for dental conditions and provide appropriate restorative and corrective treatment to this population in an appropriate setting.

Prevention is even more cost-effective than timely treatment, and multiple studies demonstrate the value and cost effectiveness of preventive dental care. It is not by chance that a majority of private dental plans cover the cost of routine preventive dental care at 100 percent without co-pays. One study showed that over a 3-year period, preventive dental treatment provided in an office-based setting was nearly 10 times less expensive than care provided in the ER.* For children on Medicaid, the system-wide savings are realized nearly immediately: research shows that low-income children who have a routine dental visit by age one incur dental expenses at *around half* of the cost level for children who don't have a routine visit until they are older (\$263 compared to \$447).⁶ The cost-effectiveness of preventive and routine dental care is undeniable—for children and adults.

OUR EXPANSION: SUCCESSES AND CHALLENGES

The following paragraphs provide a general overview of dental services at CHCRR. In 2007, 1 year after becoming an FQHC CHCRR initiated our first dental service in order to address the critical need for oral health access in our area. CHCRR rented the office of a retiring physician which was located in a “remodeled” residence over 100 years old. The layout of the facility was considerably less than ideal, but utilizing donated equipment, CHCRR was able to open a “quaint” three-chair dental office staffed with three part-time dentists who had recently retired from private practice. Our dental experience was truly a case of “if you build it they will come”—evidenced by the fact that within the first 30 days of operation the new clinic was operating beyond maximum capacity and schedules were booked 3 months in advance. During the first full year of operations at the small “make-shift” clinic, CHCRR provided 4,990 dental visits to 1,586 individual patients and provided \$253,060 in free or reduced fee dental services. Over the last 4.5 years, (mid-2007–11), CHCRR has provided over 24,000 patient dental visits and a total of \$1,062,249 in free and discounted dental services. Additionally, CHCRR provides on average \$60,000–\$70,000 annually in timely payment discounts to patients without dental insurance.

Because even after opening the dental clinic the unmet need in the community was so great, CHCRR sought ways to expand dental services further. CHCRR was able to secure a mortgage for the purchase of a 3,500-square foot facility which is ideally suited for the location of an expanded dental clinic. Additionally in support of our dental expansion plans, CHCRR was fortunate enough to secure a combination of grant funding totaling approximately \$357,000 for the purpose of purchasing necessary dental equipment and completing required renovations to create a new expanded eight-chair dental facility. CHCRR relocated its dental operations and began operating at this new expanded facility in April 2011. The new facility has allowed us to recruit additional dentists and hygiene staff in order to significantly expand the volume and level of dental services we are able to provide.

In 2012 and each year going forward, CHCRR projects that it will provide approximately 12,000 dental visits to almost 4,000 individual patients and will provide free and discounted dental care in excess of \$350,000. CHCRR believes this represents good stewardship and a good return on the grant funding used to support our dental expansion. CHCRR truly is serving a population which has traditionally had significantly reduced access to dental services. This is clearly reflected by our patient-payer mix which is currently comprised of 46.7 percent Medicaid, 44.3 percent Uninsured (91 percent Combined Medicaid & Uninsured), and only 9 percent private insurance. We believe that by providing expanded dental access to this population that we are making a significant difference in the lives of patients, improving the overall health of our community, and in the long run saving money for our health care system. It is almost impossible to put into words the truly life changing impact of something as simple as providing a set of dentures (at a total cost of less than \$500), to a patient who has gone years without teeth which prevented them from eating regular food, significantly diminished their self image, and made it more difficult to get a job!

OUR FUTURE: CHALLENGES AND VISION

CHCRR is committed to working with the local private dentists, schools, our local community, local hospital, and the State to expand dental access and increase the number of patients in our service area who have a regular dental home and source of dental care. We are partnering with our local hospital and medical home pilot to decrease inappropriate utilization of the hospital emergency room for dental conditions and facilitate transfer of that care to an appropriate dental provider. We are also incorporating annual dental screening exams as part of regular medical health maintenance visits provided at our medical clinics, and facilitating treatment for patients with identified oral health conditions who do not have a regular source of dental care. We are also developing a program to be initiated in 2012 whereby CHCRR will provide local schools with "vouchers" for a free dental check-up and evaluation. These vouchers can be distributed by appropriate school personnel to parents of children who are identified by the school as being in need of dental services or a regular dental home. The voucher can be used at the CHCRR dental clinic for a comprehensive dental evaluation and cleaning, including x rays. As part of their visit, CHCRR will work with these patients to facilitate their enrollment in Medicaid or other programs for which they may be eligible and will provide them with a regular dental home for ongoing preventive and restorative dental care.

CHCRR believes that in terms of the number of individuals without dental coverage compared to the number of individuals without medical coverage (over three times as many individuals do not have dental coverage compared to the number of individuals who do not have medical coverage), that access to comprehensive dental services is in that respect even more critical than access to medical care. Additionally, our current system does not encourage the most appropriate and efficient use of our precious and limited healthcare resources. The current system results in many patients foregoing dental treatment. The lack of dental coverage and out-of-pocket costs, actually drives a large portion of dental treatment to the emergency room setting where only symptomatic treatment is provided and at considerable added cost to our healthcare system and the overall health of our community.

For the above reasons, CHCRR believes that there is a critical need for increased access to comprehensive preventive and restorative dental services in our service area and we are fully committed to doing what we can to positively impact this situation.

CHCRR is only one of many FQHC's in Vermont and across the country that have demonstrated similar good work in expanding access to needed dental services and improving the health of the populations we collectively serve. Because FQHC's are structured around an integrated medical home model that provides a full range of primary care, behavioral health and dental services, and because of the populations they serve, FQHC's are able to orient care in a manner that is tailored and appropriate for the needs of the community and populations they serve. We believe that FQHC's are uniquely qualified and well-positioned to be a positive and useful vehicle to expand dental access in the most efficient and cost-effective manner.

Senator SANDERS. Grant, thank you very much.

Our fourth witness is Dr. Gregory Folse, who is president of Outreach Dentistry in Lafayette, LA. He has a mobile geriatric dental practice and a comprehensive school-based dental practice throughout the State of Louisiana. Dr. Folse is also the current chair of Louisiana Oral Health Coalition.

Dr. Folse, thanks very much for being with us.

**STATEMENT OF GREGORY J. FOLSE, D.D.S., PRESIDENT,
OUTREACH DENTISTRY, LAFAYETTE, LA**

Mr. FOLSE. Thank you, Senator Sanders and members of the subcommittee. With great joy I provide oral health services to the vulnerable patients we're talking about today. On the ground, the truth about oral disease and poor access to dental care is clear and undeniable to me. Poor children, the aged, blind and disabled adult Americans suffer needlessly with painful and infected teeth and gums and other unhealthy conditions. My staff and I have declared war on the diseases that affect these patients, and we're dedicated to win it.

I have two delivery models. One is a vulnerable nursing home, nursing facility model, and the other is treating Medicaid-eligible children in schools.

In my geriatric model I personally provide comprehensive portable dentistry in 24 different nursing facilities. Without the fancy comforts of an office, I provide services from simple denture adjustments to full mouth extractions and fillings. It can be done.

I employ two hygienists, one assisting with the primary triage of the patients and the other providing onsite hygiene services and facility staff education. They are invaluable professionals. Each have found and immediately referred patients in serious health crises and saved lives in the process.

General supervision regulations in Louisiana allow this model to work and allow hygienists to increase the entry points of the dental delivery system for my patients.

In 2008, I started a vulnerable children's model, and using 15 dentists, part-time mostly, and 18 expanded-duty dental assistants, we go into schools and provide care for children and have seen over 20,000 children so far, during 43,000 successful patient visits. We provide comprehensive services. This isn't a cherry-picking operation. I'm a doctor. We do it right.

I form partnerships with FQHCs, school-based health centers, and nurses to assist me in emergency referrals of these children, because a lot of the parents and families are very hard to reach, and getting those emergency services is critical.

In the old days when I started this practice, 68 percent of my patients had no teeth, compared to 80 percent who have teeth now, causing the emergency and cancer rates to skyrocket in my practice. The tragic death of Deamonte Driver was not the first oral health-related death that I've encountered. In 1995, I saw Miss Mary, who died from oral disease. Others in my practice that I've been associated with have, unfortunately, followed. The burden of disease present when a patient enters a nursing facility is profound. The lack of access to dental services between retirement and facility admission is certainly a contributing factor.

Oral health is a life and death scenario in this vulnerable population, yet many have no funding or no access to care. An absolute all-hands-on-deck policy is needed to solve the access to dental care problems in this great country. We need all delivery models engaged, whether portable or mobile services, or in bricks-and-mortar offices or non-profit clinics, regardless of which trained oral health professional is providing the care.

In Louisiana, we fought a ferocious battle over my delivery models, but fortunately access to care won. This can be done. I'm a dentist with a traditional staff who is going out and doing it in untraditional locations. My patients value my services. I don't hear "I don't like the dentist" like I used to. They line up and wait for me in the nursing facility. Miss Tammy tells me jokes. Miss Pam made me a bracelet. Miss Bonnie reached in her purse and gave me this piece of bread she had saved for herself folded in some foil. It was a special thing that she did for me because of the value she put on the services.

Now, I didn't eat it. I don't know how long it had been there.
[Laughter.]

But what I do for them matters, and they know it.

Thirty percent of the patients that I serve in my nursing facilities have no funding for care, so I donate significant amounts of care every year. No one suffers. Although this works for my patients and for me, it's not the answer. Today's dentists and other dental care providers are burdened with significant debt, and the infrastructure is not in place for them to go out and do what I do.

The overwhelming surgical needs that I see in my practice is really profound. I find many patients that live in pain without my services before they come into the facility, for sure. There are a couple of solutions out there.

One of the things that I've been able to access in my practice is the use of incurred medical expense adjustments for nursing home patients. This is a very little-known access model, a funding mechanism. The American Dental Association has recently published a really nice article, and I've got references to it in my testimony that will show you how to do it.

The other issue I think that would be a great solution is a bill that I've worked on for years, which is called the Special Care Dentistry Act. This bill would provide services to the most vulnerable patients, the aged, blind and disabled, who don't currently even have funding in my practice.

I've heard for years "it will never," "they will never," "you'll never," "we'll never." That's not true. I believe in this country and believe that in my lifetime these patients will one day have the infrastructure to access the care that they so desperately need.

I thank you for your time.

[The prepared statement of Mr. Folse follows:]

PREPARED STATEMENT OF GREGORY J. FOLSE, D.D.S.

Thank you Senator Sanders, Senator Paul, and members of the subcommittee for holding this hearing today. My Name is Dr. Gregory Folse and it is with great joy that I come to you today as a provider of oral health services to the vulnerable populations who typically have poor access to dental care. I'm honored with the hope that by sharing the details of my life's work with you, we can better the lives of the patients I serve. On the ground, the truth for me about oral disease and poor access to dental care is clear and undeniable. Poor Children and Aged, Blind and Disabled adult Americans suffer needlessly with painful and infected teeth and gums and other unhealthy oral conditions. My staff and I have declared war on the oral diseases making our vulnerable patients suffer and we're dedicated to win it. I'm here to tell you we have helped them, we are helping them, and we will continue to help them. We also routinely help others to do the same.

This endeavor will require, however, assistance from each of you to make models like mine a replicable and viable professional choice for other providers.

So what are my models? I have two—one practice treating vulnerable nursing facility residents and another mobile school-based dental practice for Medicaid eligible children.

MY GERIATRIC MODEL

In my geriatric model I personally provide comprehensive, portable, dental services in 24 nursing facilities to wonderful patients I consider to be God's children. I've developed dental director position in each facility. Without fancy equipment or the comforts of an office, I can and do provide services from simple denture adjustments to full mouth extractions and fillings. Patient autonomy and privacy, instrument sterilization, use of universal precautions, and care delivered to the same standards as in-office care can be, and are, achieved.

My practice staff includes two hygienists, one assisting with preliminary triage assessments and completing the facility's Minimum Data Set items on oral health for all residents while the other is dedicated to providing actual onsite hygiene services and facility staff education on prevention and provision of daily oral hygiene

services. They are invaluable professionals. Each have found and immediately referred to me patients in serious health crises, and have saved lives in the process. General supervision regulations in Louisiana, which allow hygienists to see patients without a dentist present, are critical to this model and help me insure patients get the care they need. Without general supervision, which fully enables a hygienist's abilities, I would not have a viable prevention model or the ability to provide my patients access to comprehensive care. Working with hygienists has increased the entry points of my patients into the dental delivery system. This is a wining model for my patients.

I do maintain a business office but no care is provided there. Two people man this ship, my office manager and my patient relations/billing manager. Both assist with normal office functions and facilitate obtaining informed consent for the patients I treat.

I travel with one trained dental assistant who assists with the treatment I provide. We have fun and do a lot of good.

All of my staff are god-sent!!!

MY VULNERABLE CHILDREN MODEL

In my vulnerable children model, I employ 15 dentists, 18 expanded duty dental assistants, and an administrative service company to provide comprehensive dental services to children in schools. Since 2008, some 275 schools have requested services and to date my teams have treated over 20,000 children during 43,000 successful patient visits. We provide comprehensive services and do not "Cherry-Pick." With state-of-the-art modern technology, fillings, stainless-steel crowns, x rays, baby tooth root canals, and some extractions can be provided to the same standards as in an office setting. We refer children to specialists when needed just as you would in an office. Followup emergency care systems are in place as are emergency referral sites. I've formed partnerships with school-based health center nurses who assist me in emergency referrals as many families are extremely hard to reach by phone. It has been reported that out of 1.6 million phone calls to families in the poorest sections of East Baton Rouge Parish school district only a 45 percent connection rate was achieved. These data prove the use of a written general informed consent form is the only way to assure access to the most vulnerable children—those whose parents can't be reached by phone.

Breaking the cycle of oral disease and neglect is, again, a major focus of my efforts for this population and oral health education is the only way to do it. We give each child dietary counseling, teach them about prevention of oral disease, and show them how to brush and floss. Additionally, these efforts ease the child into a caring and fun atmosphere which starts each visit off in a good way. The dentists who work for me are continually amazed at how well the children behave and accept treatment.

HISTORICAL PRACTICE DATA

In the old days (1992) when I started my nursing facility practice, 68 percent of my patients had no teeth and comprehensive dental services were only moderately in demand. As of September 2011, 80 percent have teeth, many more posterior teeth are present (harder to keep clean and to restore), and patients and their families are demanding preventive, restorative, surgical, and prosthetic services. The greater numbers of teeth present, coupled with the lack of dental care in the last season of life, have caused dental emergencies and oral cancer rates to sky-rocket in my practice. The tragic death of Deamonte Driver was not the first oral health death I've encountered. In my vulnerable adult dental practice I'm aware of many patients who have died and/or been sent to hospitals due to oral infections, sepsis caused from oral infections, and oral cancer. In 1995, I was involved with my first death due to oral disease patient, Ms. Mary. Others have unfortunately followed. The burden of disease present when a patient enters a nursing facility is profound. The lack of access to dental services between retirement and facility admission is certainly a contributing factor.

Conversely, I've provided life-saving dental treatment to many patients throughout the years who would have died without it. Treating serious infections, diagnosing oral lesions in time for them to be treated, and referring patients to specialists when needs exceed what I can do in facilities are all part of my routine. Oral disease found in vulnerable populations is, without a doubt, a life and death situation. I've seen it.

If there is one health care policy that enjoys almost universal support—and that's saying something in the contentious world of health care policy—it is that improving access to health care professionals is critical to improving health outcomes. Agree-

ment on how to best achieve the policy goal of improving access, however, remains elusive. Fortunately, we now have empirical data sets from places like my home State of LA that affirm two important points: (a) bringing oral health professionals to the patients works and (b) there is no one delivery model that by itself can solve the access to care crisis. An absolute “all hands on deck” policy is needed to solve access to dental care in this great country. We need all the delivery models engaged, whether by mobile/portable services or within bricks and mortar dental offices, or non-profit clinics regardless of which properly trained oral health professional is providing the care.

In LA we fought a ferocious battle, and used up a tremendous amount of energy, over the basic question of utilizing the mobile/school based model to increase access to underserved populations. Fortunately the need for access to dental care won the day due to a terrific alliance of health care professionals including Federal qualified health clinics (FQHCs), school-based health centers, physician groups, hospital groups, churches, and advocates from across the State. The lesson learned is that the promotion of and use of Practice Administrators, general, written, informed consents, and portable/mobile dental services are all vital to oral health care reform if true access to dental care is to be achieved.

THE GOOD NEWS

This can be done! I’m a dentist with a traditional staff who has made a viable go of treating wonderful and needy vulnerable patients—the patients we are all here today to serve. To me they are God’s children who greatly need and want what my staff and I provide. They value our services and I’m blessed to serve them. I don’t hear “I don’t like the dentist” like I used to. My patients line up and wait for me to arrive. Sometimes they give me simple things in appreciation: Ms. Tami tells me jokes, Ms. Pam made me a bracelet, Mr. George played a song for me on his guitar and Mrs. Bonnie gave me a piece of bread from her purse. Many can’t speak or even thank me but those give me the most joy of all—the joy of being their doctor and doing what is best for them. I want others to know these joys so I travel around the country and teach others to do what I do. There are providers using my model, or parts of it, in 17 States now, and for that I am especially pleased. Another great joy for me is knowing that I’ve helped others to care for vulnerable populations, for treating them I feel is a gift from God.

As you will see not all the patients I serve have access to funding for care. I find it rewarding to donate services to them. Annually I routinely provide tens of thousands of dollars of donated services ranging from 10 to 16 percent of my gross production. Although donating services works for my patients and for me it is not the answer. Today’s dentists and other dental care providers are burdened with significant debt. They need an infrastructure in place that will allow them to make a living while that debt is reduced. I will provide solutions to that problem later in my testimony.

A DAY IN THE LIFE . . .

The need for surgical dental services in my practice is overwhelming. As of September 2011, my practice managed oral health services for 24 nursing facilities and some 2,500 residents. Of those, 2,000 have natural teeth (are dentate) and of the 2,000 dentate patients—51 percent or roughly 1,000 needed extractions due to abscesses and/or severe gum disease. Specifically, 50 percent of dentate residents or 40 percent of the total resident population needed surgical care. Additionally, one must also consider the resident turnover rate of 30–40 percent. With 875 new patients per year and 51 percent needing surgical care, I must manage an additional 430 new surgical patients/year. The total number of patients with surgical need equals 1,430 residents per year.

I physically can’t meet this overwhelming amount of need. But I try.

Additionally, the medical intricacies of this population are complex to say the least. Most patients present with multiple medical diagnoses and are taking a myriad of medications. Managing them pre- and postoperatively is a daunting task requiring much time and effort. I’m honored and blessed, however, to do it.

WHO ARE SPECIAL NEEDS PATIENTS?

To me, poor children, children and adults with intellectual and developmental disabilities, disabled adults, the aged, frail elders, medically compromised elders, and medically compromised adults are all Special Needs Patients. From a governmental perspective, however, they are defined as Medicaid eligible poor children and the aged, blind, and disabled (ABD). For ABD adults oral health services are considered “optional.”

It is a societal sin to deny oral health services to the aged, blind, and disabled adults. How is it right for a poor developmentally disabled child to lose dental benefits when they turn 21 years old? How is it right for a poor grandmother with no money to be denied treatment of dental infection? How is it right for a 45-year-old man with intellectual disabilities and no family, who can't be treated in a traditional setting, to suffer with dental pain and have no hospital anesthesia services to cover his hospital needs?

I simply say "It isn't right."

MEDICAID FACTS—2009

According to Medicaid and Chip Payment and Access Commission (MACPAC) report to Congress dated March 2011, in 2009 62.2 million Medicaid eligible existed and, of those, 17.4 million, or 28 percent were Aged and/or Disabled (AD). Amazingly to some, the total medical expenditures for only that AD population were \$223 billion or 2/3 of the total Medicaid expenditures (plus Medicare expenditures). Specifically, 28 percent of the Medicaid population accounted for 66 percent of the total Medicaid expenditures. This doesn't surprise me at all. Half of these patients in my practice are infected, needing surgical intervention. Many live in pain and without my services would stay in pain. Their mouths teem with bacteria and disease. That bacteria gets into their bloodstream and lungs. That bacteria decreases their quality of life and often their life-span.

AVAILABLE DENTAL BENEFITS FOR THE AGED, BLIND, AND DISABLED ADULT POPULATION

So what is actually available? Medicare covers virtually nothing. Private insurance is very rare and the first to go at retirement age and in the 20 years of my geriatric practice I've had eight patients with dental insurance. As already detailed, Medicaid benefits are optional to each State although Medicaid does cover prisoner oral health services, boil and bed sore treatments, any medical infection, and heck—Medicaid will even cover a penile implant. I doubt, however, the patients receiving these implants will ever get to kiss anyone with a mouth full of decayed teeth and gum disease.

ACTIVE SOLUTIONS #1—IME ADJUSTMENTS

A special dental access mechanism is available for nursing facility residents. Incurred Medical Expense regulations can help most nursing facility residents who are enrolled in Medicaid to pay for dental care. A great article entitled *How-to guide for IME* By Stacie Crozier, ADA News staff and a corresponding document *Incurred Medical Expenses Paying for Dental Care: A How-To Guide* were written and published by the ADA. To find the article go to <http://www.ada.org/news/6295.aspx> and for the document click on the word document on the first page of the article. The article gives the reader an understanding of the law and what IME can do whereas the document details how to use IME adjustments from dental office, patient, and Medicaid Case Worker perspectives. In 20 years of practice no funding mechanism has allowed more access to dental care in my practice.

Unfortunately, IME adjustments are only allowed for Medicaid eligible nursing facility residents with a social security or pension income. Those without those income sources have no access to care through this system. Ironically, the most vulnerable residents, those who never worked like intellectually or developmentally disabled adults, have no funding for services through this system. I donate services to them routinely.

ACTIVE SOLUTIONS #2—SPECIAL CARE DENTISTRY ACT

The Special Care Dentistry Act of 2010 is near and dear to me as it seeks to create a national Medicaid Infrastructure for ABD adults. The bill supports State Medicaid oral health services for ABD adults with Federal dollars and is strongly supported by the dental profession and advocacy organizations across the country. If enacted, no poor, vulnerable population will be left without coverage and for the first time oral health services would be ensured for our most vulnerable adult population, aged blind, and disabled adults. With the rampant disease detailed in the ABD population, providing dental services to this population should prevent unnecessary medical procedures and expenditures. If passed, as infrastructure develops, and as the existing or new workforce is engaged we can better train the profession while the aged, blind, and disabled get care. The bill ensures age appropriate procedures as well as deeming that oral health services are "medically necessary." Fis-

cally it makes sense too. The bill doesn't require coverage for the entire adult Medicaid population, a costly proposition, only the most vulnerable citizens within it.

For years I've heard "It'll Never, You'll Never, They'll Never, and We'll Never." I believe in this country and know that in my lifetime these patients will one day have the infrastructure for access to dental care that they so desperately need.

WHAT HAPPENED TO DENTAL EDUCATION AND VULNERABLE PATIENT TREATMENT AND EDUCATION?

Early in the 1980s Federal and State governments began cutting financial support to dental schools resulting in today's dental schools that must be self-funded. For schools to stay financially viable a significant amount of resources must come from the students and patient pools paying for dental services. Unfortunately, the most vulnerable aged, blind, and disabled patients can't pay, dental schools can't see large numbers of them for free, and fewer are treated. Consequently, since the dental students don't treat them in large numbers, they aren't well-trained and are uncomfortable treating the aged, blind and disabled population. As tuitions rise, the dental student debt has also risen rendering many dental students fighting to make ends meet upon graduation. This can obviously negatively impact their choice to treat vulnerable patient populations.

ORAL HEALTH/GENERAL HEALTH CONNECTIONS—CDC

Poor oral health means poor health to me. Although some describe how poor oral health is linked to many medical health problems, I see it differently. You can't be healthy if you have poor oral health. There is no division of the terms in my mind. Infected teeth and gums are a significant detractor from quality of life. Patients of mine, especially disabled patients, suffer orally and those sufferings add to a host of medical complications such as the chance for infective endocarditis, sepsis, complicated diabetes ramifications, the risk of heart disease and stroke and stroke. Oral cancer is a significant killer with a horrible death rate. With regular oral exams oral cancers can be detected early when they are more easily treated. Unfortunately for my patients many haven't seen a dental provider in years and when my model finds a cancerous lesion it is rarely treatable. Death from oral cancer is a horrible death. I've seen it too many times.

Pneumonia and lung diseases are especially worrisome. A study, *Reservoir Of Respiratory Pathogens For Hospital-Acquired Pneumonia In Institutionalized Elders* by All A. EL-SOLH, M.D., MPH, FCCP; et al. detailed that of 46 patients in an ICU 28 had colonization of their dental plaques with pathogens known to cause pneumonia. Of those patients, 13 patients developed pneumonia. It was proven that 8 of the 13 patients had respiratory pathogens that matched genetically those recovered from their dental plaques. Over half of the patients in this study who got pneumonia got the bacteria that caused their pneumonia from their dental plaque. I have no doubt that providing preventive dental services to this population reduces the amount of oral bacterial and thereby should reduce the incidence of life threatening and costly pneumonia.

We all agree that bacteria in the lungs is bad and reducing the amount of oral bacterial is a primary must for aging and vulnerable patients. So who is a major front-line offensive and defensive player in my model? The dental hygienist. They help me keep my patients healthy through patient and staff education and providing preventive treatment. Unfortunately, without passage of a bill like the SCD Act, these services aren't covered for the most vulnerable ABD patients.

PRACTICE CHANGING INNOVATIONS

I'd be remiss if I wouldn't mention several practice innovations that have significantly enhanced my ability to treat poor children and ABD adults. Physics forceps, the Nomad hand-held x ray machine, digital x ray sensors, and portable dental units allowed me to provide a level of care I could have only dreamed of when I started my practice in 1992.

Senator SANDERS. Thank you very much, Dr. Folse.

Our final witness is Christy Jo Fogarty, and she is going to be introduced by Senator Franken of Minnesota.

Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Thank you, Mr. Chairman. I'm very pleased that Christy Jo Fogarty could join us today from my home State of Minnesota.

Ms. Fogarty began her career as a dental assistant, and after Minnesota became the first State in the Nation to license mid-level dental providers, Ms. Fogarty became a dental therapist. She went on to continue her education and became one of the first in the country to complete advanced dental therapist education and training.

She currently works at Children's Dental Services, a non-profit dental clinic that serves pregnant women and children under the age of 21.

Ms. Fogarty has served on the Farmington city council for 10 years and was appointed to the State Board of Soil and Water Resources in 2009. She has also served as the chair of the Farmington Economic Development Authority and has been active on dozens of advisory committees in her community.

Thank you for joining us, Ms. Fogarty.

STATEMENT OF CHRISTY JO FOGARTY, RDH, MSOHP, LICENSED DENTAL HYGIENIST, LICENSED DENTAL THERAPIST, CHILDREN'S DENTAL SERVICES, FARMINGTON, MN

Ms. FOGARTY. Thank you, Senator Sanders, and thank you, Senator Franken and committee members, for this opportunity to share Minnesota's story on expanding access to dental care through the use of a new dental provider.

As Senator Franken said, my name is Christy Jo Fogarty. I've been in dentistry for over 15 years, first as a dental assistant and then over a dozen years as a dental hygienist, and in June 2001 I graduated with a Master's in Science from the Oral Health Practitioner Program in Metropolitan State University in St. Paul. This 27-month, full-time Master's program educates students who are already licensed dental hygienists to practice advanced dental therapy.

The advanced dental therapist is a true mid-level practitioner, a provider between a dentist and a dental hygienist. It is similar to a nurse practitioner but in the dental field. The advanced dental therapist is not a replacement for a dentist. It is intended to extend the reach of the oral health care delivery system so that it will be easier and more affordable for under-served populations, including children and the elderly, to obtain high-quality oral health care services.

While Minnesota's Advanced Dental Therapy Program is the first of its kind in the United States, more than 50 other countries have educated and utilized mid-level dental providers safely and effectively for decades. Interestingly, the push to create a dental mid-level in Minnesota did not come from the dental community alone but from community groups, safety net programs, charities, hospitals, and all of the major medical insurers. They pushed for a new dental provider because so many people just couldn't find a dentist.

Emergency rooms in the Minneapolis-St. Paul area reported 10,000 visits related to oral health care problems. Only 17.5 percent of Medicaid children in Minnesota received dental treatment for services in 2010, and only 5.5 percent of Medicaid children in Minnesota received a sealant on a permanent molar in 2010. An estimated 60 percent of Minnesota dentists are expected to retire in the next 15 years.

In 2009, the Dental Practice Act in Minnesota was changed to include two new practitioners, dental therapists and advanced dental therapists, both of which are required to see at least 50 percent public assistance or uninsured patients. Dental therapists work under the indirect supervision of a dentist, which means a dentist must be onsite but not in the operatory with the therapist. This new provider—which in my opinion doesn't do much to improve access to care for vulnerable populations because of the requirement for a dentist to be onsite—this was included in the legislation largely at the urging of the Minnesota Dental Association and the University of Minnesota, who educate dental therapists.

In contrast, advanced dental therapists, after completing the Master's program, working 2,000 hours under the indirect supervision of a dentist and passing a certification exam, can then work in alternative settings without a dentist present but in collaboration with a dentist.

I am now working on getting my needed 2,000 hours at Children's Dental Services in Minneapolis. As Senator Franken said, it's a non-profit dental clinic that sees children from birth to age 21, as well as pregnant women.

I love my work. I provide all the preventive services of a dental hygienist, as well as certain restorative procedures, certain kinds of extractions, and I will have limited prescriptive authority. I also know when I need to refer to a dentist or a specialist. It's incredibly gratifying to restore someone to good oral health and teach them how to maintain good oral health.

Most of the patients I see haven't been to a dentist ever or in a very long time. I explain to every patient and the patient's parents that I am not a dentist, and I explain my background and education. I have yet to find one person to hesitate.

I recently treated a little boy who, like most of my patients, needed extensive dental work. He needed four 1½-hour appointments to complete eight stainless-steel crowns and several baby root canals or pulpotomies. After completing all of this restorative work, I was also able to clean his teeth and place sealants as a part of completing his treatment. This little boy was not only pain free, but he and his mother were well-educated on how to prevent future decay.

Another little boy I saw was only 2 years old. He had recently fallen and hit his front tooth. After a week had gone by with no dental care, the tooth turned black, was causing pain, and the child was having difficulty sleeping. By the time I saw the boy, the tooth was traumatized beyond repair and I performed the necessary extraction to relieve the pain and eliminate the infection. The boy's mother told me she had called around for hours before she was able to get an appointment in our clinic. She did not have insurance for her little boy, and dental office after dental office turned

her away both because of lack of insurance and because of the boy's age. She said we were the last call she was going to make before she brought him into the emergency room. This would have been a huge expense on the public health system, with no conclusive treatment.

What can be learned from the Minnesota experience? First, mid-levels are offering safe, cost-effective care to people who otherwise would struggle to find care. Second, no longer will seeing a dentist be the only means of accessing dental care in Minnesota. This means schools, nursing homes, community centers, really anywhere with a power source can become a place to receive dental care. And third, building on an already-trained workforce of dental hygienists means a dental therapist workforce can be achieved in a relatively short amount of time.

Please do whatever you can to make it easier to improve access to care through the exploration and utilization of new types of dental providers in Minnesota and across the Nation. I look forward to your questions. Thank you.

[The prepared statement of Ms. Fogarty follows:]

PREPARED STATEMENT OF CHRISTY JO FOGARTY, RDH, MSOHP

INTRODUCTION

Thank for this opportunity to share the Minnesota story on expanding access to dental care through the use of a new type of dental provider. My name is Christy Fogarty and I graduated in June 2011 with a Masters in Science from the Oral Health Practitioner Program administered jointly by Metropolitan State University in St. Paul and Normandale Community College in Bloomington, MN. This program, which educates students who are licensed dental hygienists already holding a baccalaureate degree, to practice as Advanced Dental Therapists. Advanced Dental Therapists provide all of the services of a dental hygienist by virtue of dual dental hygiene and dental therapy licensure, all of the services of a basic dental therapist, and additional services including oral evaluation and assessment, formulation of an individualized treatment plan, extractions of permanent moderately to severely mobile or "loose" teeth and provision, dispensing and administering antibiotics, analgesics and anti-inflammatories. The Advanced Dental Therapist is a true mid-level provider—a provider between a dentist and a dental hygienist—and is similar to the nurse practitioner who works under general supervision but in the dental field. The Advanced Dental Therapist is not a replacement for a dentist but is intended to extend the reach of the oral health care delivery system so that it will be easier and more affordable for underserved populations, including children and the elderly, to obtain high quality oral health services. An estimated 60 percent of Minnesota dentists may retire in the next 15–20 years. (UMN-Academic Health Center, Educating Minnesota's future health professions Workforce: 2008 Update) the dental workforce in rural areas has a larger percentage of dentists over the age of 59, magnifying the loss of dentists due to retirement in the near future. Twin Cities (Minneapolis/St. Paul metro area) emergency rooms reported 10,000 ER visits related to oral health problems at a cost of more than 4.7 million in 2005 (Davis, Deinard, and Maiga, 2005). In addition, only 42 percent of those on Minnesota's public health programs receive dental care, leaving low-income adults and children without needed dental care, even though every \$1 spent on preventative care saves about \$4 in dental costs (DHS, March 2007 and the National Institute of Dental Research). While Minnesota's Advanced Dental Therapy program is the first of its kind in the United States, more than 50 other countries have educated and utilized mid-level dental providers safely and effectively for decades.

A STRONG FOUNDATION IN PREVENTION

How did I begin my journey? I have been in dentistry for over 15 years, first entering the field as a dental assistant. Shortly after beginning dental assisting school I fell in love with the field of dentistry and knew I wanted to do more. Before completing dental assisting school I applied for dental hygiene school. After competing with over 300 applicants for 30 spots, I was accepted at Normandale Community

College's dental hygiene program. While in dental hygiene school, I took courses that included anatomy, physiology, biology, bio-chemistry, psychology, radiology, and pharmacology. In addition we spent hundreds of hours providing direct patient clinical care. We also spent time with patients teaching them how to prevent gum disease and tooth decay. After graduation I spent 2 years working with a private practice dentist who was very dedicated to giving back to the community and accepted a high percentage of public assistance patients. It was there I saw first hand the difficulty many people face in accessing dental care and learned how very challenging this population can be to treat. Although dental disease is almost 100 percent preventable, I saw patients with rampant untreated decay. In this practice I was able to hone my skills in prevention and disease treatment, collaborating with the dentist on treatment planning and realistic outcomes. I then moved forward with my career and began work as a temporary for hire hygienist. I was able to work in dozens of practices in the urban core of the Minneapolis/St. Paul metropolitan area, the suburbs, and the more rural areas of our State. For 7 years I witnessed private practice offices unable or unwilling to serve people with public assistance insurance, the uninsured, and people with special needs and the homebound. I have often heard that the access issue has more to do with a maldistribution of dentists and not a lack of dentists. I have witnessed firsthand many areas where people cannot enter the dental system and receive care and I saw that it has nothing to do with the availability of dentists in the area. It was at this point in my career that I heard of the big push in Minnesota to create a mid-level practitioner to improve access to dental care, and I knew I had to be a part of this new program.

MINNESOTA ENACTS LEGISLATION TO IMPROVE ACCESS TO DENTAL CARE THROUGH THE CREATION OF TWO NEW TYPES OF DENTAL PROVIDERS: THE DENTAL THERAPIST AND THE ADVANCED DENTAL THERAPIST

Interestingly the push to create a dental mid-level did not come just from the dental community but from a large cohort of community groups including safety net programs, Health Partners, Regions Hospital, the United Way, and all of the major medical insurers. In fact, over 45 organizations supported creating a mid-level point of entry practitioner (appendix A) http://www.adha.org/governmental_affairs/downloads/restorative_chart.pdf. The opposition came only from organized dentistry. In 2009 the dental practice act in Minnesota was changed to include two mid-level practitioners, dental therapists and advanced dental therapists. Dental therapists work under the indirect supervision of a dentist, which means a dentist needs to be present in the office and aware of what procedures are being completed by the dental therapist, but the dentist does not need to be in the operatory with the dental therapist. This new provider, which in my opinion, doesn't do much to improve access to care for vulnerable populations because of the requirement for a dentist to be onsite, was included in the legislation largely at the urging of the Minnesota Dental Association and the University of Minnesota that educates dental therapists. The other mid-level practitioner created is the advanced dental therapist who after 2,000 hours of working under indirect dentist supervision can work in alternative settings without a dentist present, but in collaboration with a dentist.

It is important to note that currently there is no requirement in the legislation that a dental therapist or an advanced dental therapist need to be a dental hygienist prior to licensure. However, the only advanced dental therapy program in Minnesota, which I graduated from, requires that all applicants be licensed dental hygienists with extensive dental hygiene work experience. I chose to attend Metropolitan's program because I feel the foundation in preventive care afforded by a dental hygiene education is critically important for treating this vulnerable population. By virtue of their dual dental hygiene and dental therapy licensure, graduated from Metropolitan State's program work as Advanced Dental Therapist to provide a full range of preventive oral health care services in addition to administering restorative services, performing extractions of "baby" teeth and very mobile permanent teeth and having limited prescriptive authority. This broad range of primary care services will enable me to improve access to care for rural and underserved populations and increase entry points into the oral health care delivery system. Working with a collaborative management agreement with a dentist, I will also refer patients to a dentist when they need the services that only a dentist can provide.

BECOMING AN ADVANCED DENTAL THERAPIST

I was in the first class of advanced dental therapists but getting there wasn't as easy as it may seem. I learned that despite having over a dozen years of experience as a dental hygienist I still needed more training to even be accepted into the pro-

gram. While I had the required 2,000 hours of dental hygiene experience, I also had to be licensed to administer both local anesthetic and nitrous oxide, and be certified as an REF or restorative expanded function hygienist. This certification allows licensed dental hygienists to place both silver and tooth-colored fillings, and place stainless steel crowns after a dentist has removed the decay and prepared the tooth to be restored. Note that 14 other States allow dental hygienists to provide these types of restorative services, illustrating that many States are expanding the role of non-dentist providers to increase access to dental care (appendix B) <http://www.health.state.mn.us/divs/orhpc/pubs/workforce/dent08.pdf>. I then had to go through an extensive application and interview process. Once accepted into the accredited, 27 month, full-time masters program I started very challenging coursework. This included clinical coursework that taught us the new skills we would be performing.

We were taught these skills, within the scope of our practice, to the same level as a dentist. In other words our training to prepare teeth, remove decay and fill teeth was taught in the same matter dental students learn it across the country everyday. In addition, we took coursework in advanced pharmacology, epidemiology, managing patients with special needs, and pediatric dentistry (appendix C) http://www.metrostate.edu/msweb/explore/catalog/grad/index.cfm?lvl=G§ion=1&page_name=master_science_oral_health_practitioner.html. While learning new skills is always challenging my background was very useful in learning treatment planning, assessments, and prevention education as these were critical thinking skills I had used for over a decade as a dental hygienist. In our clinical training I was able to see dozens of uninsured patients in our home clinic allowing me to restore hundreds of teeth before ever officially entering the field of dental therapy. We also were able to do rotations through Community Dental Clinic, Hennepin County Medical Center in their pediatric and oral surgery departments, the VA nursing home and Children's Dental Services. These experiences allowed us not only more clinical time with patients but allowed us to work directly with experts in the field to expand our critical thinking skills.

While completion of this master's level education was the most significant requirement for licensure in Minnesota there were still several additional requirements I had to complete prior to being allowed to practice dental therapy in Minnesota. I had to complete a clinical exam on both a typodont or "fake" teeth, and I had to complete two fillings on actual patients. The patient portion of the exam was taken with dental students from the University of Minnesota and other dental students from across the country. The evaluators in this process did not know which patients were being treated by a dental student or an advanced dental therapy student, again this shows that in our scope of practice, we are trained to the level of a dentist. After passing the dental boards I then had to find employment in order to gain the 2,000 hours of experience as a dental therapist before being eligible to take the certification exam that will certify me as an Advanced Dental Therapist. Finding work was not challenging as Children's Dental Services was eager to hire an advanced dental therapist. In fact, they have another licensed hygienist currently in the program they intend to hire.

Children's Dental Services is a non-profit dental clinic that sees children from birth to age 21. And because education of new mothers on how to take care of their children's gums and teeth is so critically important, we also see pregnant women to not only improve their oral health, affecting their overall health, but to educate them on preventive care for their children. Children's Dental Services also does mobile dentistry, bringing care to over 150 metro site including schools, community centers and hospitals. Statewide we have over 200 sites allowing us to bring much-needed dentistry directly to the children who most need care. We also see children with special needs, having taken our mobile units over an hour and a half away to treat deaf and blind children in their schools. We also offer translators in almost a dozen languages. This helps to remove language as a barrier to dental care, and increases our ability to educate patients and parents on preventive oral care. The final piece to being able to practice dental therapy in Minnesota was to find a dentist to collaborate with. Again this was not as challenging as I thought it might be. The dentists I work with at Children's Dental Services were very supportive quite frankly because they knew and trusted me because of my work as a dental hygienist. As a result I have not just one but five dentists I am in collaboration with, with several more willing to sign with me.

EFFECTS ON ACCESS DENTAL THERAPY IS HAVING TODAY

As a practicing dental therapist, I see firsthand every day the difference I make in opening access to dental care. As a full-time dental therapist I see anywhere from

6–10 patients a day. For example, in the month of January alone I saw 57 patients who needed numerous restorative procedures. In addition to referrals and triaging I did 4 space maintainers, 5 pulpotomies (root canals on baby teeth), 11 stainless steel crowns, 17 extractions and 47 fillings. I also saw 12 emergency patients that could have otherwise ended up in the emergency room where they would have been given antibiotics and pain medications and told to find a dentist. There really is no dental emergency room. A medical emergency room simply isn't able to provide oral health care services but only to administer palliative treatment to alleviate the pain and prevent infection.

On one occasion I saw a 2-year-old boy who had fallen and hit his front tooth. After a week had gone by without dental care, the tooth had turned dark and was causing him pain, making it difficult for him to sleep. By the time I saw him, the tooth was traumatized beyond repair and I performed the necessary extraction to relieve the pain and eliminate the infection. The boy's mother told me she had called around for hours before she was able to get an appointment with our clinic. She did not have insurance for her little boy and dental office after dental office turned her away because of the lack of dental insurance and because her little boy was under the age of 3, which is the standard age most private dental practices in Minnesota begin to see children. She said we were the last call she was going to make before she brought him to the emergency room. This would have been a huge expense on the public health system, with no conclusive treatment. When I become an advanced dental therapist, after completing 2,000 hours as a dental therapist, I will become even more effective as a point of entry into dental care. I will have the ability to work in schools, community centers, nursing homes, virtually anywhere that dental needs are going unmet.

PUBLIC ACCEPTANCE IN MINNESOTA OF NEW DENTAL PROVIDERS

From my vantage point, the acceptance level of dental therapy is nothing short of amazing. Every patient I see I explain to them that I am not a dentist and that I am a dental therapist. Once I explain to them that a dental therapist is much like a nurse practitioner in medicine they are comfortable with me treating their children. I have never once had anyone say they would prefer to see a dentist. In many cases, because I am a licensed dental hygienist, I have also cleaned their teeth so the parents are already comfortable with me, and I have developed trust with them. In fact, there was an 8-year-old boy I saw recently who had never been to the dentist before for several reasons including struggling with finding a dental office who would take their public assistance insurance. Unfortunately, as is the case with the vast majority of the population I see, this little boy needed extensive dental work. He needed four 1½ hour appointments to complete eight stainless steel crowns and several baby root canals, or pulpotomies. After the first appointment with me the mother said, "I don't care if you're a dentist or not I want my son to see only you." After completing all of this restorative work, I also was able to clean his teeth and place sealants as a part of completing his treatment. This little boy was not only pain free but he and his mother were well-educated in how to prevent future dental decay.

WHAT CAN BE LEARNED FROM MINNESOTA

Minnesota is the first State to take the mid-level practitioner and fully integrate it into dentistry and many things can be learned from what we are doing. First, mid-levels are offering safe, cost-effective care to people across the State, opening up access to dental care to people who otherwise would have struggled to find care. I myself am seeing over 50 patients a month. Second, no longer will seeing a dentist be the only means to entering the dental system. Traditionally the only way a patient could seek dental treatment was to first see a dentist but with Minnesota's legislative changes it is now possible for advanced dental therapists to assess and treat dental pain without the patient first having to see a dentist. This means schools, nursing homes, community centers, really anywhere with a power source can become a place to receive dental care. Advanced Dental Therapists are also able to assess and refer not only to our collaborating dentist but also to specialists if the needed treatment is outside our scope of practice. This enables the patient to get needed treatment faster and more efficiently. Third, utilizing an already trained workforce of dental hygienists means getting a dental therapist workforce can be achieved in a relatively short amount of time. In fact in Minnesota there are over 5,300 licensed dental hygienists. This is an incredible and largely untapped resource that can help open access to dental care not only in Minnesota but across the country. At the same time we have this large dental hygiene workforce where we are looking at a shortage of dentists in the very near future with nearly 18 percent of

the 3,300 practicing dentists in Minnesota planning to retire in the next 5 years (appendix D). <http://www.mnsafetynetcoalition.org/OHP%20Proposal%20Supporters.pdf>.

CONCLUSION

For over 50 years nurse practitioners have provided quality, safe, effective medical care to people across the country, opening up a new entry point into the medical care delivery system. It is time to do the same for dentistry. Too many people struggle to enter the dental system and mid-level providers can be that additional entry point and help access desperately needed dental care. In addition to opening access, mid-level dental providers can also help decrease costs. Mid-level advanced dental therapists are paid far less than dentists therefore employment at places like Children's Dental Services can decrease costs and provide safe, quality, effective dental care for those most in need.

Frankly, it has been tough slugging in Minnesota. I have faced delays in credentialing, struggles with processing insurance claims, and as a I work toward my 2,000 hours needed to become an ADT, the Minnesota Board of Dentistry is still working a process to test dental therapists to allow licensure as ADT's. Despite the challenges in becoming and working as a mid-level dental provider but I am proud to be persevering and so gratified to see the result of our work with patients suffering from the pain of untreated dental decay and look forward to continuing to serve those who would likely not have had access to needed dental care without me. Please do whatever you can to make it easier to improve access to care through the exploration and utilization of new types of dental providers in Minnesota and across the Nation.

Attachments—Appendix A

**Organizations in Support of Establishing
Minnesota's Oral Health Practitioner**

- Aging Services of Minnesota
- Arc Greater Twin Cities
- Arc of Minnesota
- BlueCross BlueShield of Minnesota
- Children's Dental Services
- Children's Defense Fund Minnesota
- Community Action Head Start
- Community Dental Care
- Consortium for Citizens with Disabilities
- Disability Law Center
- Ecumen
- ElderCare Rights Alliance
- HealthPartners
- Hennepin County Medical Center
- Hennepin Faculty Associates
- Lake Superior College
- Lake Superior Community Health Center
- Legal Services Advocacy Project
- Local Public Health Association
- Medica
- Metropolitan Health Plan
- Metropolitan State University
- Migrant Health Service
- Minnesota Association of Community Health Centers
- Minnesota Association of Community Mental Health Programs
- Minnesota Council of Health Plans
- Minnesota Dental Hygienists Association
- Minnesota Dental Hygiene Educators' Association
- Minnesota State Colleges and Universities
- Minnesota Visiting Nurses Association
- National Dental Association
- National Rural Education Association
- National Rural Health Association
- Native American Community Clinic
- Neighborhood Health Care Network
- Neighborhood Involvement Program
- Normandale Community College
- NorthPoint Health & Wellness Center
- Open Door Health Center
- Partnership to Improve Children's Oral Health
- Portico Healthnet
- PrimeWest
- Regions Hospital
- Sanford Health Plan of MN
- Scenic Rivers Health Services
- Southside Community Health Services
- Three Rivers Community Action, Inc.
- United Way Bright Smiles
- West Side Community Health Services

Appendix B

Dental Hygienists Restorative Duties By State



State	Apply Cavity Liners & Bases	Place & Remove Temporary Restorations	Place/Remove Temporary Crowns	Place/Carve/Finish Amalgam Restoration	Place & Finish Composite Resin Silicate Restoration	Requirements
AK				Allowed*	Allowed*	Board Approved Course WREB or Equivalent Exam
AI	Allowed*	Allowed*	Place Only*	Prohibited	Prohibited	
AR		Place*		Prohibited	Prohibited	Program
AZ						
CA	Allowed**	Allowed**	Allowed**	Allowed* <small>Requires TGA/EF License</small>	Allowed* <small>Requires TGA/EF License</small>	
CO						
CT		Prohibited			Prohibited	
DC	Prohibited	Allowed		Prohibited	Prohibited	
DE		Prohibited	Prohibited	Prohibited	Prohibited	
FL	Allowed	Allowed	Allowed	Prohibited	Prohibited	
GA	Allowed*		Allowed*			
HI				Prohibited	Prohibited	
IA	Allowed*	Allowed*				
ID	Allowed*		Place Only*	Allowed	Allowed	Restorative Endorsement, WREB or Equivalent Restorative Exam
IL				Prohibited	Prohibited	
IN						
KS						
KY	Allowed*		Allowed*	Allowed*	Allowed*	Proof of competency
LA				Prohibited	Prohibited	
MA	Prohibited	Remove Only*	Allowed*	Prohibited	Prohibited	
MD		Allowed	Allowed	Prohibited	Prohibited	
ME		Allowed	Allowed*	Allowed*	Allowed*	Board approved EFDA program

*Can do services by virtue of inclusion in dental assistant's scope of practice. Please check practice act for educational requirements.
 **Allowed for an RDH, RD-IEF, or RDHAP license prior to 2006.

1 | Prepared by staff of the American Dental Hygienists' Association, October 2011

Dental Hygienists Restorative Duties By State



State	Apply Cavity Liners & Bases	Place & Remove Temporary Restorations	Place/Remove Temporary Crowns	Place/Carve/Finish Amalgam Restoration	Place & Finish Composite Resin Silicate Restoration	Requirements
MI	Allowed*	Allowed*	Allowed	Allowed*		Registered Dental Assistant took approved course
MN		Allowed*	Allowed*	Allowed	Allowed*	Board approved course to place & adjust permanent restorations <small>Note: MN also permits RDH to place, contour and adjust glass ionomer</small>
MO		Allowed*		Allowed*	Place Only*	Proof of Competency
MS						
MT		Allowed*		Prohibited	Prohibited	
NC	Allowed*	Place Only*				
ND	Prohibited	Allowed*	Allowed*	Prohibited	Prohibited	
NE				Prohibited	Prohibited	
NH	Allowed	Allowed	Allowed*	Place		Expanded Duty Course
NJ		Allowed*				
NM		Allowed	Allowed	Allowed	Allowed	EFDA Certification
NV		Place Only	Allowed			
NY		Allowed*		Allowed*	Allowed*	Approved Course
OH		Allowed*		Place Only	Place Only	
OK		Place Only				
OR				Allowed*	Allowed*	Board Approved Course, WREB or Equivalent Exam, Restorative Function Endorsement
PA	Allowed*			Allowed*	Allowed*	
RI		Allowed		Prohibited	Prohibited	
SC				Prohibited	Prohibited	
SD		Place Only		Prohibited	Prohibited	
TN	Allowed	Allowed		Place Only		Restorative Function Permit

*Can do services by virtue of inclusion in dental assistant's scope of practice. Please check practice act for educational requirements.
 **Allowed for an RDH, RD-IEF, or RDHAP license prior to 2006.

2 | Prepared by staff of the American Dental Hygienists' Association, October 2011

Dental Hygienists Restorative Duties By State



State	Apply Cavity-Liners & Bases	Place & Remove Temporary Restorations	Place/Remove Temporary Crowns	Place/Carve/Finish Amalgam Restoration	Place & Finish Composite Resin Silicate Restoration	Requirements
TX	Prohibited	Prohibited	Prohibited	Prohibited	Prohibited	
UT						
VA						
VT						
WA		Allowed*	Allowed*	Allowed*	Allowed*	Trainings expanded function. Restorative services in curriculum of Washington Dental Hygiene programs. WREB restorative required for dental hygiene license. Replacement of temporary restorations in emergency situations only.
WI		Place Only				
WV	Allowed*	Allowed*	Allowed			
WY		Place Only		Allowed (with EP Certificate)	Allowed (with EP certificate)	Expanded function certificate no longer offered, but existing certificates honored.

This chart is for comparative purposes only. If information does not indicate whether one of the functions is prohibited or allowed, no assumptions should be made.

Disclaimer: Information based on staff research of state statutes and legislation. This document should not be considered a legal document.



*Can do services by virtue of inclusion in dental assistants scope of practice. Please check practice act for education requirements.
**Allowed for an RDH, RDHEF, or RDHAP licensed prior to 2006.

3 | Prepared by staff of the American Dental Hygienists' Association, October 2012

Appendix C—Advanced Dental Therapy Courses

INTERDISCIPLINARY COURSES

Epidemiology

This course focuses on the fundamentals of epidemiology and the application of this knowledge to interpreting scientific research related to health and disease at the population level. The scientific principles and conceptual framework of epidemiology are presented. Through the course, the student gains an understanding of epidemiology as the science of public health and community health nursing and dental therapy/advanced dental therapy by examining the range of health problems and diseases affecting diverse cultures, races, and ethnic groups.

Theories and Explorations: Community-Based Intercultural Communication

Theories and Explorations in Community-Based Intercultural Communication has a global perspective while engaging students in community-based projects and topics. Theories are learned to help students develop their ability to apply a comparative perspective to cross-cultural communication episodes in interpersonal interactions. Students research topics of interest that evolved out of their own communities to better understand the social, economic, religious and political values and practices of a specific immigrant/refugee group. Through reading and textbook students learn the knowledge and theories of Intercultural Communication; through library research students learn in depth about one specific culture's belief system; and students practice and learn skills needed to engage in respectful and sensitive communication with others whose beliefs, values, and attitudes are different than their own through their community-based project.

Health Policy and Leadership

Students achieve a contextual understanding of selected health care systems, focusing on social, cultural, economic, and political variables. The U.S. population-

based, market-driven system is studied in depth. Federal, State and local health policy areas of responsibility are explored. Nursing and dental therapy/advance dental therapy leadership roles including client advocacy and political activism are studied. An experiential component includes lobbying an elected official and exploring nursing and dental roles and issues related to health policy with an advanced practice nurse or dental therapist/advanced dental therapist.

Designing for Quality in Health Care (Formerly Research)

This course focuses on clinical and operational excellence and continuous improvement of quality and safety from the leadership perspective. Topics include process improvement philosophies and approaches, process design for quality results, system analysis for error prevention, program evaluation, measurement and use of data, responding to less than perfect results, critical communications, and current topics in patient safety and quality in health care delivery.

DENTAL COURSES

Health Assessment and Oral Diagnostic Reasoning

This didactic and clinical course focuses on the significance of systemic and oral diseases and their connection to dental patients. Oral Health Care Practitioner student skills in dental therapy/advanced dental therapy patient evaluation, assessment, treatment planning within the context of dental collaborative management agreements, and consultations/referrals will be emphasized. This course develops a comprehensive, patient-centered, problem-solving approach to clinical evaluation, assessment and treatment planning stressing the development of critical thinking and clinical judgment. Socio-cultural, familial, environmental, and developmental influences across the life-span will be considered. In addition, emphasis is on health promotion, disease prevention, and the management of common oral health problems.

Pharmacological Principles of Clinical Application

This didactic course prepares the Oral Health Care Practitioner student to provide proper care for patients who are taking medications and to administer medications as outlined in MN Statute 150A.106 that complement clinical dental therapy/advanced dental therapy care delivery. Providing, dispensing, and administering analgesics, anti-inflammatories, and antibiotics within the context of advanced dental therapy scope of practice and collaborative management authorization is a course focus.

Management of Dental and Medical Emergencies

This didactic and laboratory-based course reviews common medical and dental emergencies that may be seen by dental therapists/advanced dental therapists in the dental setting, as well as, management protocols and prevention strategies for emergencies. This course illustrates the relationship between accurate data collection and achieving successful outcomes in the management of dental and medical emergencies. Emphasis is placed on gathering, analyzing and processing information to develop appropriate action plans.

Community-Based Primary Oral Health Care I

This lecture and laboratory-based course is the first in a series of courses taught throughout the curriculum that provides learning opportunities leading to competency in dental therapy/advanced dental therapy practice. In a simulated setting the course emphasizes operative dentistry techniques that restore form, function, and esthetics to faulty teeth with the purpose of contributing to both oral and general health. The basic principles of tooth preparation and restoration, and the appropriate selection and application of direct restorative materials, are emphasized. Focus is on theoretical and laboratory principles of operative dentistry utilizing direct placement restorative materials in the permanent dentition.

Community-Based Primary Oral Health Care II

This lecture and laboratory-based course builds upon the concepts and skills learned in Community-Based Primary Oral Healthcare I. The laboratory emphasis of the course is restorative dentistry for the pediatric and adolescent patient in a simulated setting. Course concepts and strategies include behavior and trauma management; management of the developing occlusion; oral evaluation, assessment,

and treatment planning within the context of collaborative management agreements; preventive strategies; and restorative care for the pediatric and adolescent patient within the dental therapist/advanced dental therapist scope of practice. Collaborative management agreements and indications for professional referral/consultation to provide comprehensive patient care are also a course focus.

Community-Based Primary Oral Healthcare III

Community-Based Primary Oral Healthcare III consists of lecture, laboratory, and clinical components. The lecture component of the course is a continuation of previous coursework preparing the master's student for dental therapy/advanced dental therapy clinical experiences. The laboratory component provides simulation and dental laboratory experiences with complex, direct restorative procedures, repair of removable oral prostheses, and fabrication of preventive, removable oral appliances. The clinical component of DENH 660 provides initial experiences in the delivery of dental therapy/advanced dental therapy services and patient management in the clinical setting. Implementation of professional referrals and consultations to ensure comprehensive care is also emphasized. All course components are under direction of licensed dentists.

Community-Based Primary Oral Healthcare IV

Community-Based Primary Oral Healthcare IV consists of lecture, laboratory, and clinical components. The lecture component is a continuation of the curriculum preparing the student for the scope of practice as a dental therapist/advanced dental therapist. The didactic and laboratory components provide students with the theoretical and applied skills addressing the dental therapy/advanced dental therapy scope of practice related to exodontia and brush biopsies. The clinical course component offers MS: OHCP students the opportunity to develop skills in providing primary oral healthcare to underserved patients across the life-span while under direction of licensed dentists. The development of professional referrals and collaborations are also emphasized to manage comprehensive patient care.

Community-Based Primary Oral Healthcare V

This seminar and clinically based course provides the MS: OHCP student with opportunities to further develop and refine their skills in providing primary oral healthcare to underserved patients across the life-span under supervision of licensed dentists. Additional development and refinement of skills and concepts necessary for the delivery of dental therapy/advanced dental therapy primary oral health care services is the course focus. In the clinical setting ethics, responsibility, and self-evaluation and self improvement continue to be emphasized, as well as, professional referrals and consultations to provide comprehensive patient management.

Advanced Specialty Clinic

This seminar and practicum-based course provides the MS: OHCP student with practical experiences in delivering dental therapy/advanced dental therapy primary oral healthcare services to special needs patients in extended campus clinical settings while under the supervision of a licensed dentist. Patient groups encountered with special needs may include: pediatrics, geriatrics, medically compromised, patients with genetic and/or acquired disabilities and financially or motivationally impaired patients.

Advanced Community Specialty Internship

This seminar and practicum-based course offers in-depth experiences providing primary oral health care services to a special needs patient population of the Masters in Science in Oral Health Care Practitioner student's choosing. Emphasis will be placed on providing dental therapy/advanced dental therapy primary oral health care dental services under the guidance of a supervising dentist for one of the following underserved populations: pediatric; geriatric; medically, mentally, or psychologically compromised patients; financially and/or motivationally impaired patients. Competent, professional dental therapy/advanced dental therapy treatment requiring consideration beyond routine approaches and the comprehensive management of patient-centered dental problems is a focus.

Comprehensive Competency-Based Capstone

This course is the culmination and synthesis of the educational experiences of the Masters in Science of Oral Health Care Practitioner student. Integration and application of independent critical thinking and problem solving skills, professional attitudes, ethics, sound clinical judgment, and primary oral health care skills are essential to dental therapy/advanced dental therapy practice success and will be demonstrated through clinical practical experiences. A final scholarly paper and poster presentation focuses on a topic relevant to dental therapy/advanced dental therapy practice and will demonstrate the writing and communication skills necessary for the Master of Science degree.

Appendix D

Minnesota Dentist Workforce Data

Source: Office of Rural Health and Primary Care, Minnesota Department of Health (2008). Workforce Demographics for Minnesota Dentists.

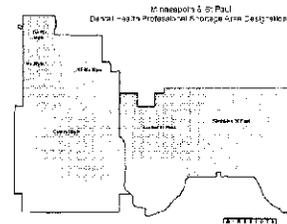
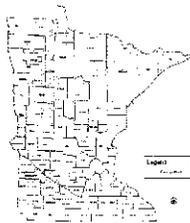
Number of Dentists

- 2,970 dentists were practicing at least part time at Minnesota practice sites in 2007-08.
- The Office of Rural Health and Primary Care estimates that **Minnesota has approximately 57 active dentists per 100,000 people**.
- Dental practices are mostly located in metropolitan areas and small cities and regional centers.
- **The 46 most rural counties have 12.6% of the state's population, but only 8.5% of the state's practicing dentists.**
- **In 2003, many regions of the state were below the statewide average of 63 dentists per 100,000 people (See Table 1)**
- Portions of 38 counties, mostly in rural western and northern Minnesota, as well as large parts of the cities of Minneapolis and St. Paul, are designated dental health professional shortage areas.

Minnesota Region	Estimated Dentists per 100,000 Residents*
Northwest	52
North	52
North Central	48
West Central	52
East Central	46
Southwest	41
South	64
East South Region	60
Statewide Statistic	63

* Figures based on 2007 data. Data is not available for unpopulated areas. * Excludes dentists practicing in correctional facilities and military or aviation settings.

Health Professional Shortage Areas
Dental Dentists



Age of Dentists

- **Half of all dentists are 50 years old or older; 40% are 55 or older.**
- **Rural dentists are older than urban dentists.** The greatest difference appears when the median age (51) of dentists in metropolitan area counties is compared to the median age (55) for the 46 rural counties.
- **More than half of dentists in rural counties are 55 or older.**

Race and Ethnicity

- Minnesota's dental workforce is mostly white.
- **93% of the state's active dentists are white, compared with 89.3% of the state's population (2007 census)**
- Less than 1 % of dentists identify themselves as of Hispanic or Latino origin.

Practice

- **Nearly one-in-five (18 %) active dentists plan to work another five years or less.**
- 25 % percent of dentists aged 55-64 expect to work less than five more years.
- **Retirements are more imminent in rural areas.**
- **17% of dentists under age 35 said they plan to work at most another five years.** This figure may suggest a level of job dissatisfaction among young dentists or decisions to leave the workforce while raising children.
- Two-thirds (67 percent) of dentists working in Minnesota report working 36 hours per week or less; **the median hours worked in 2007 was 35.** 58% percent work 21 to 36 hours.

Senator SANDERS. Thank you very much, Ms. Fogarty.

We've been also joined, in addition to Senator Franken, by Senator Bingaman, who has long been interested, I know, in the issue of dental care, and we appreciate him being here.

Let me start off by being provocative, if I might. We have heard from all of you, I think, and everybody here on our side, that we have a crisis in this country, that we have millions of people who don't get to a dentist when they should. We have people who are suffering. We have people who get ill because of dental problems.

In your judgment, and I'll start off with Dr. Edelstein and go on down the line, has the American Dental Association or State dental societies been aggressive in standing up and saying we have a problem and, as the professionals dealing with this issue of dentistry, we're going to solve this problem? Has the American Dental Association or State dental societies stepped up to the plate and done what they have to do to protect the dental needs of the American people?

Who wants to start off on that one? Dr. Edelstein or anyone else.
Dr. Edelstein.

Mr. EDELSTEIN. My personal involvement in public policy to address the issues that you've raised began after working as a Senate staffer on the original SCHIP legislation, and I noted at that time the absence of attention by my associations to the issue of access equity and the consequences thereof.

As a member of the American Dental Association who receives their publications on a regular basis, I can't help but notice the tremendous increase in attention that the organizations bring to their members about the problem. I think we have turned the corner on organized dentistry's recognition that there is a significant issue.

There certainly has been collaborative effort by multiple organizations, child health organizations, health organizations, hospital organizations, safety net organizations, and dental associations in addressing some of these issues through legislation, in particular a terrific coalition that was created around the enactment of the CHIP reauthorization, and I want to recognize Senator Bingaman for his tremendous leadership in these oral health provisions.

In direct answer to your question, I would say that there is a tremendous increased awareness and much work to be done. Because we need the dentists to deliver the services so often—again, we can't work without the dentists—it's critical that they be actively engaged.

Senator SANDERS. Any other comments on that?

Ms. Fogarty, in Minnesota, have you had the cooperation of dentists?

Ms. FOGARTY. If I may, I'm going to speak very candidly.

Senator SANDERS. Please.

Ms. FOGARTY. The Minnesota Dental Association, and the American Dental Association for that matter, have been staunchly opposed to mid-level providers. And in Minnesota particularly, when we were fighting to get this legislation passed, the American Dental Association, instead of funneling thousands of dollars into trying to find solutions into the access to care issue, they funneled thousands of dollars in Minnesota to fight mid-level practitioners, particularly dental hygienists.

The original legislation was actually intended to be, just as I am, founded in prevention, founded from hygienists, and we wanted to create an advanced practice dental therapist or dental hygienist, which was the original title. Many compromises were made, as whenever you're doing new legislation there is, and "therapist" was what we came up with for a final title. But the only reason that we have dental therapists and not exclusively advanced dental therapists who also have licensure as dental hygienists is because of the dental association and the University of Minnesota.

And I think that foundation in prevention, as you heard from everybody on this panel, prevention is where we want to get so we're preventing disease and not just treating it. And if you create a practitioner who only treats diseased teeth, you're missing a great big piece of that picture, and it was organized dentistry who fought to make sure that we had practitioners who had no foundation in prevention.

Senator SANDERS. OK. Dr. Folse, do you have any thoughts on that?

Mr. FOLSE. Yes. As I mentioned, there was a ferocious fight in my State over the mobile portable care that I provide in schools. There was even a bill that was backed by the Louisiana Dental Association—

Senator SANDERS. Say that again. The dental society opposed a mobile dental clinic for low-income children?

Mr. FOLSE. Yes. They opposed my portable dental practice in Louisiana that goes into schools and treats patients that actually don't have dentists. I researched the Medicaid rolls and made sure that they don't have a dentist of record for the last 12 months.

From that fight, however, we learned a lot of things. They are not prepared to continue fighting those access models and have re-engaged with me to some degree in helping me to do it. The Louisiana Dental Association did promise a plan to address the same things that I'm doing, which hasn't occurred.

While I was fighting in Louisiana on the ground level to be able to continue to provide services, the bill actually banned the practice of dentistry on school grounds. While I was fighting there to do that, the American Dental Association on the other hand, on a national level, was looking into what I was doing and backing me. They brought me up to a Medicaid symposium as an expert. I presented on my program, and it's been recommended as a viable model to go across the State.

So you've got some differences there in the philosophies. I don't think that we'll see another battle like we had in Louisiana anytime soon.

There is one other thing that goes on, though, that's of major importance, and that are the dental regulatory boards. A dental board can set up regulations that will stop this access to care. Right now, to get informed consent on all of these patients, which is a major issue, if I have to call all of the families of the children that we treat, I'm looking at a 40 to 45 percent connection rate to the family. That's not talking to a parent to get consent. That's connection rate. So the most vulnerable children, those families that don't have phones, that the parents don't answer the phone call, if you

require a phone conversation with that family, you'll never treat the child.

What we use is a general written informed consent that the family signs, and it's got all the medical documentations that we need, and it allows care to the most vulnerable children that are out there. A board can regulate that out and stop me from seeing the most vulnerable.

Senator SANDERS. Thank you very much. My time is over. Let me give the mic to Senator Mikulski.

Senator MIKULSKI. Well, I want to thank you all, each and every one of you, for what you're doing every day to make sure the needs of vulnerable populations are taken care of. We've talked about children. We've talked about people in nursing homes. We've talked about the blind. We've talked about special needs. These aren't the lucrative, prosperous and pampered patients that are looking for cosmetic super-whitening. Nothing wrong with that, but you really obviously are very duty-driven people, and we want to thank you for what you do.

Dr. Edelstein, we talked in Baltimore, so I'm not going to ask you questions. I really want to go to Ms. Fogarty and Dr. Folsie.

Ms. Fogarty, what you're talking about really sounds like an innovative way to support the dentist. The dentist will perform certain procedures that only a dentist can do, but not everything the dentist does can only be performed by a dentist. And doesn't this parallel pretty much the battle the nurse practitioner/physician assistant movement went through 40 years ago?

Ms. FOGARTY. Yes, same battle 40 years later, a different part of medicine.

Senator MIKULSKI. And yet in any modern practice, clinicians value what a nurse practitioner or a physician's assistant can do, and it hasn't resulted in the loss of prestige, power, or income to doctors. Is that correct?

Ms. FOGARTY. Right. In fact, I've heard many doctors say they don't know what they would do without their nurse practitioners.

Senator MIKULSKI. So I would hope that as for you and your efforts, there are lessons learned from winning those battles, and for the American dental establishment to take lessons learned from this incredible workforce social movement.

Now, what States license your level of practice?

Ms. FOGARTY. Minnesota is the only State. Well, I shouldn't say that. Minnesota is the only State that has this type of the advanced dental therapist. Alaska does—

Senator MIKULSKI. Are you licensed to do this?

Ms. FOGARTY. I am licensed to do dental therapy currently. I'm completing my 2,000 hours so I can become an advanced dental therapist.

Senator MIKULSKI. What I need to know is this. I know what a nurse practitioner is.

Ms. FOGARTY. Yes.

Senator MIKULSKI. And you have a license to be a nurse. A person can get a nurse practitioner, OK?

Ms. FOGARTY. I'm licensed to do dental therapy in the State of Minnesota.

Senator MIKULSKI. But tell me, is this the mid-level care?

Ms. FOGARTY. Yes.

Senator MIKULSKI. I don't want to get lost, because people won't know the distinction between dental therapy and dental hygienist. It's a very confusing terminology.

Ms. FOGARTY. Correct.

Senator MIKULSKI. That's not a negative comment. But if we're going to be advocates, we've got to speak in plain English to win the support of the people.

Ms. FOGARTY. Correct.

Senator MIKULSKI. We're never going to win the support of the establishment until the establishment knows it can benefit their practice and their pocketbook. You solve those two problems, you solve their willingness to support you.

Ms. FOGARTY. I carry both a license as a dental hygienist and as a dental therapist. I have dual licensure.

Senator MIKULSKI. So what I'm looking for is—so Minnesota is the only one. So other States who might want to adopt this, you're the only one. Or if we wanted to have Federal encouragement in this area, Minnesota is the only one?

Ms. FOGARTY. Correct.

Senator MIKULSKI. And is that because of this stymieing from the establishment?

Ms. FOGARTY. I can't speak to other States. I just know in Minnesota it was quite a battle against organized dentistry.

Senator MIKULSKI. So where did you get your training? At the dental school? Where did you get your training?

Ms. FOGARTY. I got my training at Metropolitan State University in collaboration with Normandale Community College. The University of Minnesota has a different type of program for a different type of licensure.

Senator MIKULSKI. So is this a universally recognized curriculum?

Ms. FOGARTY. It's an accredited program, yes.

Senator MIKULSKI. Which can be duplicated and replicated in every State?

Ms. FOGARTY. Absolutely, absolutely.

Senator MIKULSKI. Well, Mr. Chairman, I think my time is really almost up on this. The reason I pursued this was there's not going to be enough dentists to go around, and no matter what models we adopt, and there are several here, we're looking at the community public health. If you live in a food desert, your only access is to cupcakes and fried chicken, you're going to have other issues, for children or adults. So we have to look at other models.

This is a promising model, and we have lessons learned from the nurse practitioner/physician's assistant that as a movement became programs that I think have really helped, particularly in the area of primary care.

Senator SANDERS. Yes.

Senator MIKULSKI. I would hope that we could look at lessons learned, talk with you about how we can encourage this, and encourage dental schools and so on to do it. And for our dental establishment, I would hope they would look at what other modalities benefited from practitioner physician's assistant, because it did not affect their power, it did not affect their prestige, it did benefit pa-

tients which we're sure every clinician is connected to, and it didn't shrink their pocketbook.

Ms. FOGARTY. Correct.

Senator MIKULSKI. Isn't that kind of what it is?

Ms. FOGARTY. That's exactly what it is.

Senator MIKULSKI. Thank you. Dr. Folse, what you're doing really warmed my heart. When you talked about your patients, you can see you clearly love them, and that's why they love you. But you show them love every day with your big smile and making sure they have one, and that's true of everybody here.

And by the way, if I could tell the rest of the story about Deamonte, his mother was a woman of modest means, but after the tragedy of Deamonte she made sure she got her education. She's a dental hygienist today.

Senator SANDERS. Is that right?

Senator MIKULSKI. Isn't that a sweet ending to the story? So let's have more sweet endings with big smiles.

Senator SANDERS. Thank you, Senator Mikulski.

Senator Bingaman.

STATEMENT OF SENATOR BINGAMAN

Senator BINGAMAN. Thank you very much, Mr. Chairman.

Let me ask Dr. Folse, I'm very interested in your children model, vulnerable children model. How are you reimbursed for those services in schools?

Mr. FOLSE. Through Medicaid.

Senator BINGAMAN. Medicaid in Louisiana provides a level of reimbursement. Is it an adequate level of reimbursement to cover your costs, or not?

Mr. FOLSE. It is an adequate level of reimbursement. It's gone down the last couple of years, but we're still making a viable go of it.

Senator BINGAMAN. Are you the only one in Louisiana doing this in the schools with a mobile unit?

Mr. FOLSE. There were more before the issues occurred, but now there are, I believe, three other FQHCs that are providing portable care. I think there are 12 portable permits that have been applied for and given by the State Board of Dentistry.

Senator BINGAMAN. And what about in other States? Do the FQHCs in other States do this as well? I'm not familiar with this kind of a mobile unit going into the schools on a regular basis in my State.

Mr. FOLSE. I'm not the one to ask that about FQHCs. I've heard of others in other States doing it, but I don't have data on that.

Senator SANDERS. Mr. Whitmer, did you want to respond to something?

Senator BINGAMAN. Yes, please go ahead.

Mr. WHITMER. I can add some comment to that. In Vermont, there are five FQHCs that have banded together and operate a mobile van. They receive some funding to help from the Ronald McDonald House, and the van pretty much travels around to the different communities and schools throughout the area providing services where it's needed.

Senator SANDERS. Senator Bingaman, without taking your time, I would also point out that in Vermont we now have four school-based clinics where we have chairs in schools, in the schools, not mobile clinics, and they're working phenomenally well.

Senator BINGAMAN. That's great. As part of the service that you provide in the schools—I was briefed at one point on some type of a sealant that is put on kids' teeth at a certain age, and this was something that some States were trying to do for all of their 3d graders or all of their 6th graders or something. Is that anything that's gone on in Louisiana, anything you're involved in, Dr. Folse?

Mr. FOLSE. Yes. In my practice we provide sealants, age appropriately, on all the children that we see. Additionally, we do fillings and stainless-steel crowns and baby tooth root canals and little extractions. It's a comprehensive dental program. In the space of this table, I can set up a dental office and do great dentistry for children.

There are sealant programs that are run by the Department of Health in-hospital as well, and we work in conjunction with them where we go into a school and are doing the comprehensive care. They don't do the sealant programs there. We make sure that we don't—there's plenty of work for everybody to do, and so we work together on those issues.

Senator BINGAMAN. I guess one obvious question is where is the initiative coming from to get these services provided in the schools? Is it something that the State of Louisiana decided, OK, we're going to do this, and let's find some dentists who want to participate and got in touch with you, or is this something you initiated?

Mr. FOLSE. In the State, I initiated it and approached different school districts with the idea. At first I didn't know if it would be a viable model, and the response was pretty overwhelming. We're in the New Orleans area, the Baton Rouge area, and the Shreveport area and surrounding parishes, and weekly different schools are calling us, asking us to go in.

My limiting factor is manpower in having enough dentists working for me. Roughly 15 dentists work part-time. Some work a day a week. I think I have three full-time dentists now.

Senator BINGAMAN. It does seem as though if you're looking for cost-effective ways to provide useful health care, this kind of a program for kids in schools, where you could line up the kids and provide the services to a lot of kids at one time, it would seem like this would qualify.

Mr. FOLSE. It's a wonderful program, and I think the most important part of it, besides the oral health education that we do for each child, is that we're treating the vulnerable, those that aren't going to get seen elsewhere. And when you can focus on that population, you've really done something.

Senator BINGAMAN. Thank you very much. My time is up.

Senator SANDERS. Thank you, Senator Bingaman.

Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman, for inviting me to attend this important hearing today. I'm very proud that my home State of Minnesota is the first in the Nation to create a license for mid-level dental providers called dental therapists.

It's my understanding that most other developed countries have dental therapists. Is that right? Does anybody want to jump in on that?

Ms. Fogarty.

Ms. FOGARTY. Yes, that's true. The vast majority of Europe has dental therapists—New Zealand and Australia. The dental therapists that they have in Alaska are the dental aide therapists. They were actually first trained in New Zealand.

Senator FRANKEN. Right.

Ms. FOGARTY. And they've been active—

Senator FRANKEN. We had a hearing about them in Indian Affairs, and they were doing remarkable work. In villages, in Native villages in Alaska, these small villages, they would not see a dentist for a year, and once a year a dentist would fly in and do some dental work. Instead, through BIA, they trained these dental therapists in New Zealand and then they went back. These were Native peoples in Alaska, and it made a tremendous difference because then your dental therapist could see the kid in the store and say, "Oh, brush your teeth every day." You know what I mean? I mean, that's important, right? And it's somebody they know. It's not the dentist that flew in.

Thank you, Ms. Fogarty, for coming into Washington to testify.

The Institute of Medicine recently reported that many Americans have trouble getting access to dental care, particularly those in rural areas, children, older adults, and racial and ethnic minorities. Just tell me how are dental therapists such as yourself uniquely able to help meet the oral needs of those often under-served and overlooked populations?

Ms. FOGARTY. Well, the No. 1 thing that we're doing is we're adding to the workforce. And it's been said again and again, there aren't going to be enough dentists. We have to find new modalities to be able to get access to care.

Currently, I am seeing probably about 50 patients a week. Many of them I'm triaging and funneling into either hygiene or doing the work myself, or if it's something beyond my scope of practice, I'll get it referred to the dentist.

But much to the question Senator Bingaman said is our non-profit organization at Children's Dental Services, we have over 150 offsite locations doing much of the same type of work in the metropolitan area, and over 250 statewide. So we're going into schools, into community centers, and for me, once I become an advanced dental therapist, I can go to those schools and be the primary caregiver for everyone in that school. There will be very little in this population that I can't complete onsite at a school without a dentist present. So if that's not opening up access to care, I don't know what is.

Senator FRANKEN. And you're an advanced dental therapist.

Ms. FOGARTY. I'm training to be an advanced dental therapist. I have to complete my 2,000 hours before I'm licensed. Currently I am working with a dentist in the office. But after 1 year of full-time work, I do work full-time, that will change.

Senator FRANKEN. Ms. Gehshan, same question. How are you able to serve these under-served communities or people?

Ms. GEHSAN. Well, I work for the Pew Center on the States, and our project supports campaigns in a number of States to help them develop new workforce models. We're currently working in California, Maine, and New Hampshire, and we helped out in Minnesota when the legislation was passed in 2009.

We don't advocate a one-size-fits-all answer, because the needs are different in States and they have different resources to build on. Some, for instance, have a shortage of hygienists, so a hygiene-based model might not make sense. Some States lack training programs. In New England, for instance, there may have to be a regional approach to train new types of providers.

But it's very clear that new providers could augment the care that the current dental system provides and are critically necessary, and the evidence supports it. What we hope will happen is that Congress will put funding into the Alternative Workforce Demonstration Program that was created in the Affordable Care Act. It would be the best way to get objective evidence about how to use the new models to actually reach those who are outside the system, not to compete with dentists but to just make sure that everyone has access to quality care.

Senator FRANKEN. I'm running out of time, but your recommendation would be, and I kind of hear that the panel's recommendation would be that in light of the fact that a lot of dentists are going to be retiring and we're going to have a workforce shortage in dentists, that this model of the middle-level dental therapist, that every State do what Minnesota is doing. Is that fair to say?

Mr. Edelstein.

Mr. EDELSTEIN. Yes. If I could, I'd like to put the workforce issue in the context that we at the Children's Dental Health Project have been working on for the last 15 years. Recognizing that workforce is a critical element, we carry what we call our five buckets. Workforce is one, the safety net is another, coverage and financing a third, prevention a fourth, and surveillance to find out what's working and what isn't a fifth.

So I would suggest that it is a multifaceted problem. It's a systems delivery problem, and those are only on the delivery side. There are also the issues of engaging families with health education and motivation to participate in their own care, but most of all to make sure that the benefit of prevention really reaches people because, as I mentioned earlier, the legislation is already there to address this comprehensively. Workforce is an important piece of it, but right now Congress is focused on the coverage piece, and the coverage is essential if we're going to get people into chairs.

Senator FRANKEN. Well, I think that's an impressive bucket list. [Laughter.]

And I thank you, Mr. Chairman.

Senator SANDERS. Senator Franken, I'm going to do another round of questioning, and you're more than welcome if you have any others.

Senator FRANKEN. I think I have to go to Judiciary.

Senator SANDERS. OK. Thank you.

Senator FRANKEN. But thank you all. Thank you for all your work.

Senator SANDERS. Thank you.

We have heard about the problems, and we have talked about some solutions. Let me discuss one area where I think there's great potential, and we're seeing it working out in the State of Vermont.

In recent years, we have seen a significant increase in the number of Federally Qualified Health Centers. We've gone from two to eight, and we now have nine FQHC dental practices in the State. As I go around the State, including to Mr. Whitmer's organization in Rutland, what we are seeing is just beautiful state-of-the-art dental facilities that are taking a whole lot of folks. In fact, in Vermont, a State of about 630,000 people, we now have 25,000 people getting their dental care through FQHCs.

Mr. Whitmer, I've been down to Rutland on a number of occasions, and I remember that small practice. Talk a little bit about the need that you saw in Rutland County when you opened the practice and what's happened since.

Mr. WHITMER. Well, it truly was a case of "if you build it, they will come." We certainly saw the critical need for dental access, but as a new and fledgling FQHC, we didn't even know what we didn't know about dental care at the time, but we knew we needed to try to do something.

We actually got donated equipment, rented a retiring physician's practice and really, I guess they would call it, cobbled together a quaint dental practice, and I'm not exaggerating the fact that within 30 days it was beyond capacity.

It was truly amazing because that initial clinic was staffed with three recently retired part-time dentists, and all of them, over the course of—after we'd been doing it for a while, had remarked—I usually met once a month with all the dentists, and they all remarked that it was some of the most rewarding work that they'd done in their career, probably the most rewarding time of their career, and the stories of individuals that were just so grateful and thankful for the care that they had received and the difference that it made in their lives.

I mean, you just can't over-state the impact of somebody that has really gone without teeth, unable to really afford or find a place to get dentures, and something that is as simple as getting dentures that not only allows them to eat better—I mean, if you eat without teeth, you have to eat certain kinds of foods. You're not able to really even eat a balanced diet. It has impact on nutrition and everything else.

But more than that, just the self-respect and image, the change in their self-image that was evident in these patients was truly, truly heartwarming, and it really was kind of the genesis for us to really make the decision that we needed to do whatever was necessary to expand the access; because, quite frankly, the dental services have a net financial negative impact on our practice, and we provide the service because there is a critical need, and because we really do believe, as has been said by others on this panel, our system, not only is there an access problem, but our system is created so that, I would call it—well, I don't want to say squandering, but we're certainly not using the resources that are being spent toward dental care in the most effective manner. And done in an appropriate fashion, we could certainly do a better job and get a lot more people healthy.

Senator SANDERS. Now, I know that you have moved out of your quaint old office into a new office with new chairs. Do you have a waiting list there? Are people coming to that office as well?

Mr. WHITMER. We've certainly expanded. We've more than doubled the capacity in that clinic, and at this point our limiting factor—we've talked about the workforce. Our limiting factor is recruiting new additional dentists to be able to provide those services.

Senator SANDERS. OK. That takes us to another area which I'd like to go. Generally speaking, dentists make a decent living. I mean, their incomes are pretty high. Why is it that we have actually a dental shortage in this country? Before we even get to the issue of dental therapists, let me just start off with dentists. Why do we not have enough dentists? I know that in Vermont, and I suspect around the country, FQHCs struggle to bring dentists in. We have tripled funding for the National Health Service Corps. That's helped, but we've got a long way to go.

So why do we have a shortage of dentists in this country? Who wants to take a shot at that one?

Ms. Gehshan.

Ms. GEHSAN. I'll take a shot at that one. The supply of dentists ebbs and flows over time. In the 1970s and 1980s there was the biggest crop of new dentists trained and graduating and entering the workforce, and they are the ones that are beginning to retire now in larger numbers. But there also was a recession back then which led to pressure to close a number of those dental schools, and only now, because of how high the incomes are for dentists, are there new dental schools cropping up.

The only thing that I would say about it, though, is that there's no evidence whatsoever that shows that if you add more dentists to the system, we're going to reach the one-third of the population that's outside, because most of them are practicing in good faith to the best of their ability but in the system that they inherited, which largely takes care of insured and private-pay patients who don't need very much.

And so where we need innovation and where we need the alternative workforce demonstration programs is to think about new delivery systems and a wider array of providers to reach the one-third.

Senator SANDERS. Well, you were very generous in what you said. But the bottom line is, I think translated into hard English, is you've got many dentists who are not treating low- and moderate-income people. Is that what you're kind of saying?

Ms. GEHSAN. Well, yes.

Senator SANDERS. My understanding is, and somebody correct me if I'm wrong, that just about 20 percent of dentists in this country will treat people with Medicaid. That's a fact, is it not?

Ms. GEHSAN. Senator, that's true. I do think that Medicaid is something of a mess. I think everyone would admit that. The rates are too low. Some of the policies that States adopt are designed to make it hard for both providers and for patients to get in, and case management would help enormously. There's research that shows that if you pay for case management, patients are less likely to not show up for an appointment.

But I think that many of those are policies that we could really address. I mean, the Institute of Medicine recommended a number of changes in dental education so that we start producing different types of dentists who are more likely to serve under-served patients.

Senator SANDERS. Dr. Folse.

Mr. FOLSE. Yes. I'd like to address this in the context of the aged, blind, and disabled, and the cost for me personally when I started this practice back in 1992, with no funding from Medicaid except for denture care, which I think was very low at the time for a set of dentures. I suffered greatly for probably 15 years in this practice as far as income, probably the lower 10 percent of dentists as far as my income is concerned.

Without the infrastructure present, I would probably still be doing it because I'm called to do this. This isn't really a choice for me. The advent of my understanding of the incurred medical expense allowances has finally put some income for the services that my patients need. A recent graduate coming out of dental school that wants to do this kind of care that doesn't know about the IME is going to be facing the same things I faced 20 years ago, and it's just a difficult thing. Without that coverage for the aged, blind, and disabled patients, we aren't going to get very much diversity no matter who is providing the care.

So I think, looking at that, and again I talk about the Special Care Dentistry Act because it focuses funding for the true vulnerable in the country, the aged, blind and disabled adult, and if we can get those covered, all the nursing home patients would be covered, all of the intellectual disability patients, developmentally disability patients, when they reach that 21 years old where they've had coverage before and now all of a sudden they're on the street as far as oral health is concerned, that bill would take care of all of that and at least allow us to develop the infrastructure to treat them.

Senator SANDERS. Mr. Whitmer.

Mr. WHITMER. You said one comment. I think I'll use an example that we were fortunate enough to recruit two new female dentists right out of school this year, I mean wonderful dentists. They're in it for the right reasons.

But quite frankly, and I was really astounded when I heard this, and I think you were down there and heard it directly from them, but each of those dentists graduated with over \$350,000 worth of debt, OK? And without the National Health Service Corps and the loan repayment that it provides, they would not—I mean, they really had a calling and were really interested in serving this population. But without that loan repayment assistance, they would not probably have been able to go to an area to be able to serve this population.

I just wanted to give that feedback, that these people are graduating with sometimes higher debt than physicians.

Senator SANDERS. Yes.

Mr. WHITMER. And the National Health Service Corps really has made a difference for us in being able to recruit those people.

Senator SANDERS. Dr. Edelstein.

Mr. EDELSTEIN. Senator, you've raised both FQHCs and Medicaid, dentist participation in Medicaid. I wanted to highlight a program that links the two together.

Because FQHCs become so quickly swamped with patients and have to pedal hard to try to keep up with the volume, one of the solutions that the Dental Health Project, working with HRSA and CMS and the National Association of Community Health Centers and the ADA, developed is contracting of dentists to community health centers. This expands the availability of services for the FQHC. The patient remains the responsibility and the patient of record of the FQHC, but it introduces patients who are vulnerable to private practitioners who may not yet be Medicaid providers. So it has a number of solutions.

It introduces the Medicaid patient as a person who the dentist can develop a relationship with on referral of the FQHC, and it expands the FQHC capacity.

Senator SANDERS. OK. Are there any brilliant questions that I haven't asked that you would like to answer?

I would also mention that Senator Jay Rockefeller, who has long been interested in this issue, has given us a statement that we'll put into the record.

[The prepared statement of Senator Rockefeller follows:]

PREPARED STATEMENT OF SENATOR JOHN D. ROCKEFELLER, IV

Mr. Chairman, I want to thank you for holding this hearing on the dental crisis in this country, a crisis that has worried me since my days as a 1964 VISTA volunteer in West Virginia when we worked to bus school children to the dentist. At that time, many of these children had never had dental care, and although we have made great improvements, particularly for our children, we have an uphill climb to get to where we should be.

Dental care is important to overall health—and that's as true in adulthood as it is in childhood. But sadly, care for adults and seniors has lagged behind. This is the reason that I pushed for an amendment to the health reform legislation to add dental services for Medicare patients—and, although we were not able to succeed, it's why I'm working on legislation to make affordable dental care for our seniors a reality once and for all.

As you are well aware, the crisis in access to dental care is even more pronounced in rural areas of our country such as the State of West Virginia. Rural areas have fewer dentists per capita, are less likely to have the preventive advantage of fluoridated water supplies, and are less likely to have dental insurance coverage as a benefit of employment.

Just this week, we learned that more Americans are turning to emergency rooms for basic dental care. This drives up health care costs and it means that pain and suffering are going untreated. This backward system can result in tragedies such as the death of 12-year-old Deamonte Driver 5 years ago. Health care and dental care should not be a luxury. Let's all work to raise awareness about the importance of oral health, starting within the first few years of a child's life to see them grow into strong, healthy adults.

Thank you, Mr. Chairman, for giving this problem the attention it deserves.

Senator SANDERS. Ms. Gehshan.

Ms. GEHSAN. Senator, this is not a brilliant question, but I do have one more thing to say, which is that one of the functions of State dental directors, which are funded by the Centers for Disease Control infrastructure grants that I mentioned before, is to do planning for the State, and I think it's really critical that that funding be available for all States because that actually adds data to these discussions in States about what the needs actually are and takes it out of the political realm a little bit. It helps States move forward on workforce as well as prevention.

Senator SANDERS. This is an issue that this committee is going to stay on because I think it's an issue of enormous importance that does not get the kind of discussion and attention that it deserves. And there's one other part of the issue that we did not really go into, and maybe I'll ask that as a last question, but I want to pursue it in the future, and that is why dental care is so very expensive.

I mean, the truth of the matter is, if you trip on the stairs and you knock out a couple of teeth, it's going to take many, many thousands of dollars to replace those. Why?

Dr. Edelstein.

Mr. EDELSTEIN. The answer to the question relates also to the prior question about the training of new dentists. The reason that so many of those schools closed at that time was because the colleges and universities found the cost of providing dental care to be so high. Medical students are trained in their medicine, basic medical knowledge in the university, but they get their clinical training in the hospitals. Dental students have both their basic training and their clinical training inside the university. The costs are tremendous for delivering that care, and as Mr. Whitmer mentioned, it's hard to clear a profit even within the FQHC model, although with efficiencies that are inherent in the FQHC, they're doing well.

The same issue relates to the cost of dental care in the private office. Each office is a complete surgical suite. And so the tremendous infrastructure costs that accrue to hospitals accrue also to offices. Now, there are ways around it. Certainly, Dr. Folse has demonstrated that mobile approach. There are efficiencies in larger offices. There's a strong trend in America toward larger group practices. There are efficiencies to be had.

But the way things are structured at the moment, the delivery of care is itself very costly, and the demand high, the supply low.

Senator SANDERS. Well, let me just conclude by thanking all five of you. I think your testimony was great. We're going to shine a spotlight on an issue that is not talked about, and we're going to do our best to solve this problem. So, thank you all very much for participating.

Mr. FOLSE. Thank you, Senator.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF THE ACADEMY OF GENERAL DENTISTRY (AGD)

The Academy of General Dentistry (AGD) is a professional association of more than 37,000 general dentists dedicated to staying up to date in the profession through continuing education. Founded in 1952, the AGD has grown to become the second-largest dental association in the United States, and it is the only association that exclusively represents the needs and interests of general dentists. More than 772,000 persons in the United States are employed directly in the field of dentistry. A general dentist is the primary care provider for patients of all ages and is responsible for the diagnosis, treatment, management and overall coordination of services related to patients' oral health needs.

While patients who avail themselves of dental services in the United States enjoy the highest quality dental care in the world, many people are underserved presently. This raises the need to address both access to care and utilization of care. Access to care refers to the availability of quality care, and utilization of care refers to the behavior and understanding necessary by patients to seek care that is accessible.

Illnesses related to oral health result in 6.1 million days of bed disability, 12.7 million days of restricted activity, and 20.5 million lost workdays each year.¹ However, unlike medical treatments, the vast majority of oral health treatments are preventable through the prevention model of oral health literacy, sound hygiene and preventive care available through the dental team concept.

The AGD believes the role of the general dentist, as leader of the dental team, is of paramount importance in improving both access to and utilization of oral health care services. The AGD believes that all Americans deserve good oral health and oral care delivered by fully trained dentists.

Recognition of the important role oral health plays in an individual's overall health continues to grow, as for the first time the Department of Health and Human Services' "Healthy People" series, Healthy People 2020, recognized oral health as a leading health indicator in the Nation's overall health.

The statement for the record of the hearing submitted by the American Dental Association provides an excellent discussion of the many barriers to optimum oral health in this country. AGD will take this opportunity to focus on two issues: oral health care for children and the role of the dental team.

ORAL HEALTH CARE FOR CHILDREN

A number of States are working to improve access to dental services for the underserved. Nowhere is the dental crisis more evident than the children in underserved populations. While all children covered by Medicaid and the Children's Health Insurance Program (CHIP) have coverage for dental services, ensuring access to these services remains a concern. The AGD is committed to identifying and implementing strategies for increasing participation by general dentists in providing oral health services to children enrolled in Medicaid and CHIP.

Increased participation by general dentists is an integral part of a national strategy for increasing access to care for children and their families. Efforts to improve access must include initiatives designed to address the barriers to bringing more general dentists into the Medicaid and CHIP programs. In order to increase participation, there first is a need to better understand the barriers to participation before strategies for overcoming these barriers can be developed. A part of this process is to facilitate a robust discussion between those who currently participate in providing Medicaid and CHIP services and those who either do not or do so on a very limited basis.

To better understand the role of general dentistry in these programs, AGD, in 2011, surveyed the members of the Pennsylvania Academy of General Dentistry (PAGD). The respondents were asked about their participation or lack of participation in Medicaid and CHIP. The survey also asked about incentives that might encourage greater participation in either or both programs.

Based in part on the survey results, AGD is exploring a possible collaboration with the Centers for Medicare & Medicaid Services (CMS) to explore strategies that can be adapted by the States to increase participation by general dentists and strategies for use by AGD and CMS to urge greater participation by dentists.

¹U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2000. NIH publication 00-4713. Available from www.surgeongeneral.gov/library/oralhealth.

The ability of a dentist to participate in State Medicaid/CHIP plans is based primarily on the quality of the State plan and adequate reimbursement rates for dental Medicaid and CHIP programs. According to research published in the July 12, 2011 edition of the *Journal of the American Medical Association*, “higher Medicaid payment levels to dentists were associated with higher rates of receipt of dental care among children and adolescents.”

There are other strategies that if adopted, could increase participation rates by dentists. Case management (making appointments for children in the dental office for full exams and assisting caregivers in overcoming family-related obstacles to care) and addressing the broad range of issues that dentists have with payors, for example, would signify huge steps forward.

Additional factors influence dental utilization and access for both children and adults, including:

- Economic barriers, such as a lack of Medicaid coverage for dental services for adults and an inability to pay for services by those who do not have dental insurance;
- Cultural barriers, such as a lack of knowledge about the importance of preventive dental care; and
- Individual barriers, such as lack of transportation or an inability to get time off from work.

With the Pennsylvania results in hand, AGD is undertaking a national survey of AGD members with the same purpose of gaining a better understanding of the factors that determine whether a general dentist participates, and to what extent, in Medicaid, CHIP, and other pro bono services. AGD will also inquire into other practice strategies being used by general dentists to reach low-income populations and identify successful involvement by general dentists.

There is a strong cohort of AGD members who provide dental care through Medicaid and CHIP. We are confident that by working together, AGD and CMS can increase the size of the cohort and increase the number of children who regularly see a dentist.

THE DENTAL WORKFORCE

The existing dental workforce model is a proven delivery system. Comprised of fully trained and licensed dentists, dental hygienists and dental assistants (expanded function dental assistants in some States)—the existing dental workforce model is adaptable to virtually any situation.

We often hear that there is or will be a shortage of dentists, but recent studies project that the number of dental school graduates will steadily increase through the year 2030. The real issue to be addressed is the staggering cost of a dental education. According to the American Dental Education Association, upon graduation from dental school, the new dentist will have student loan debt in excess of \$200,000. This level of debt impacts the individual’s career path and limits choices upon graduation. Many are forced by economic necessity to practice in a corporate setting rather than going into private practice or practicing in underserved areas.

Congress should consider expanding and protecting the National Health Service Corps Loan Repayment Program, by providing recently graduated, licensed dentists with a cost-of-living stipend and educational loan forgiveness in exchange for practicing in underserved communities, lowering interest rates for educational loans, and creating more general practice and pedodontic residencies to help those living in underserved areas.

Many groups have offered models intended to provide clinical services—including surgery—to underserved populations. However, there is no empirical evidence, other than studies that reach preconceived conclusions, to support the economic feasibility of training independent mid-level providers, such as dental therapists, to perform irreversible, surgical procedures. In fact, it raises significant concerns about the quality and safety of the resulting dental care provided to underserved populations. This questionable model has the strong potential to lead to the establishment of a two-tiered oral health care system where the poor—especially the minority poor—and the geographically disadvantaged would be subjected to second-class care from inadequately trained oral health providers.

To advocate for independent mid-level providers to provide unsupervised care to underserved patients is not only economically unfeasible but also ill-advised as it works against the prevention model. Because underserved patients often exhibit a greater degree of complications and other systemic health conditions, the use of lesser-educated providers risks jeopardizing the patients’ health and safety. This approach will provide lesser-quality care to the poor.

The independent mid-level provider model is often compared to physician assistants or nurse practitioners, generally omitting the significant differences among those models.² Physician assistants and nurse practitioners require up to 6 years of post-high school education, not the 2 years or less suggested for many dental therapist models.³ Surgical procedures are not part of the scope of practice of medical mid-levels, in stark contrast to the proposed dental mid-level providers.

Are we really ready to give up on bringing underserved populations into the existing dental care system based on the dental team? We are concerned with the near-obsessive focus on independent mid-levels as the ultimate solution to access problems. The solution should not be the creation of a sub-level tier of unsupervised, non-dentists, who practice outside of the dental team, to diagnose, drill and perform other dental procedures on the poor or geographically disadvantaged. This approach would be a disservice to the poor and disadvantaged communities.

There is no single solution that will resolve all barriers, but progress is being made. As documented by the American Dental Association in their statement for the record for this hearing, dentists working with their State and community leaders have been successful in helping to alleviate barriers. For example, dentists in Maryland have secured an expansion of dental Medicaid, bringing care within reach for more of the State's citizens. After the tragic death of Deamonte Driver, the Maryland Department of Health and Mental Hygiene convened a Dental Action Committee (DAC). The DAC developed a dental action plan that included recommendations such as increasing reimbursement levels, developing a culturally appropriate oral health message for the target population and training dental and medical providers to provide oral health risk assessments, among others. According to data reported to CMS, dentists' participation increased from 743 in July 2008 to 902 in February 2010 and utilization rates increased for children enrolled in the program from 31 percent in 2007 to 36 percent in 2008.⁴

The dental team concept provides the patient with a dental home for continuity of comprehensive care with a focus on prevention and treatment to forestall or mitigate the need for cost-ineffective critical care. It also best ensures that the patient will receive appropriate, competent and safe care.

The AGD believes the role of the general dentist, as leader of the dental team, is of paramount importance in improving both access to and utilization of oral health care services.

The AGD is willing and able to work with other communities of interest to address and solve disparities in access to and utilization of care across the Nation. We should work together to ensure that all Americans receive the very best in comprehensive dental care to achieve optimal dental health and overall health.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF PEDIATRIC DENTISTRY (AAPD)

The American Academy of Pediatric Dentistry (AAPD) is pleased to offer comments to the subcommittee on this important topic. The AAPD appreciates the subcommittee's focus on this issue and its concern for improving the oral health of America's most vulnerable children. Founded in 1947, the AAPD is a not-for-profit membership association representing the specialty of pediatric dentistry. The AAPD's 8,000 members are primary oral health care providers who offer comprehensive specialty treatment for millions of infants, children, adolescents, and individuals with special health care needs. The AAPD also represents general dentists who treat a significant number of children in their practices. As advocates for children's oral health, the AAPD develops and promotes evidence-based policies and guidelines; fosters research; contributes to scholarly work concerning pediatric oral health; and educates health care providers, policymakers, and the public on ways to improve children's oral health. The AAPD's reference manual of clinical guidelines is the most extensive of any organization in dentistry, and is the benchmark for promoting the highest quality of clinical oral health services for America's children. ***The AAPD wants to ensure that the best interests of children come first and foremost in any strategies to address access to oral health care.***

Pediatric dentists care deeply about access to care and are currently serving those with the greatest needs. The AAPD is strongly committed to improving the oral

²American Academy of Physician Assistants. "What is a PA?" Retrieved March 7, 2012. http://www.aapa.org/the_pa_profession/what_is_a_pa.aspx.

³U.S. Congress. Senate Health, Education, Labor, and Pensions Committee Subcommittee on Primary Health and Aging. "Dental Crisis in America: The Need to Expand Access." (Date: 2/29/12). Text from: American Dental Association Statement for the Record. Available from: http://www.ada.org/sections/newsAndEvents/pdfs/ada_testimony-committee_on_help_subcomm_primary_health_aging.pdf.

⁴Ibid.

health status of America's children, through a variety of advocacy, service, and public education initiatives.

Pediatric dentists provide a disproportionately greater amount of care to Medicaid children. According to a recent AAPD survey, **over 70 percent of AAPD members are Medicaid providers.** This is supported by a recently published survey which found that **pediatric dentists devote close to 20 percent of private practice delivery to children qualifying for public assistance programs.**¹ Given the data, one can extrapolate that 20 percent of the 4,396 average total patient visits provided per year by the Nation's 5,300 active private pediatric dental practitioners **equals an estimated 4.66 million Medicaid visits per year.** This does not include the significant amount of free care that is provided by pediatric dentists who find the administrative burden of Medicaid participation to be too onerous and expensive to be feasible. Additionally, many pediatric dentists participate in free-care events such as Give Kids a Smile and Missions of Mercy.

The pediatric dentist workforce is growing and diversified. The AAPD for the past 15 years has advocated an increase in the number of pediatric dentists; thanks to congressional support for health professions training funds (Title VII of the Public Health Service Act) for primary care dental training, **the number of first year residency positions in pediatric dentistry has increased by 200 over this timeframe.** Nearly 60 percent of trainees are female. A 2008 article "The Impact of Title VII on General and Pediatric Dental Education and Training" presented a comprehensive review of the impact of the title VII program on general and pediatric dental training.² The main conclusion was that the program has been important in the growth and expansion of residency training in pediatric and general dentistry, by facilitating a more diversified dental workforce and providing outreach and service to underserved and vulnerable populations. Furthermore, "As the need for more pediatric dentists and general dentists with advanced training is expected to continue, title VII's role in expanding workforce capacity, and in supporting [general dentistry and pediatric dentistry] curricula, will remain important in the foreseeable future."³

The AAPD made significant progress in establishing dental homes for children in Head Start during the 2007–10 AAPD-Head Start Dental Home Initiative. Our Regional Oral Health Consultants, State Leaders and project staff successfully implemented strategies to meet the goals of the initiative—that every Head Start and Early Head Start child across the country have a dental home and that Head Start staff and parents have the information they need to ensure that every child in Head Start has optimal oral health. Hundreds of new providers were recruited to provide dental homes to Head Start and Early Head Start children across the country. New collaborative partnerships were developed at the State and local level in States that launched the initiative, sometimes bringing Head Start, dentists, Medicaid representatives and other stakeholders to the same table for the first time. Most importantly, families that have struggled to obtain dental care were able to access a true dental home.⁴ Unfortunately, the Office of Head Start decided to fold this program into a larger center for health grant and significantly reduced funding for the dental home initiative. Now, the agency is back to their prior failed approach of providing informational resources to Head Start personnel to pass along to parents/guardians, rather than linking directly with the practicing community to ensure that Head Start children have access to a dental home.

AAPD members contribute funds, time and other resources personally to help disadvantaged children obtain dental care as well as through our charitable foundation. More than 25 percent of AAPD members have given to Healthy Smiles, Healthy Children: the Foundation of the AAPD (referred to as HSHC) at least once during the last 3 years, allowing the foundation to provide Access to Care grants which have helped over **1.6 million children nationwide to date.** HSHC Access to Care grants are part of a pilot initiative launched in 2009 to provide matching and challenge grants of up to \$20,000 to support local initiatives providing care to underserved or limited-access children. Originally established as a complement to the AAPD's *Head Start Dental Home Initiative*, the Access to Care grants represent the centerpiece of the Academy's social responsibility and outreach efforts. HSHC will award 10 additional Access to Care grants in the spring of 2012, totaling \$196,000, and hopes to double the number of grants awarded in 2013. These Access to Care grants are funding programs such as:

- Homeless Children's Oral Health via Herman Ostrow School of Dentistry University of Southern California
- Geisinger Health System Foundation Every Smile Counts (PA)
- The Dental Foundation of Oregon The Tooth Taxi Mobile Dental Clinic
- Indiana Dental Association Born to Smile Program
- The Ohio State University Nisonger Center Johnstown Road Access to Care

- Illinois Chapter, American Academy of Pediatrics Bright Smiles From Birth: An Oral Health Education and Technical Assistance Program

The AAPD is committed to improving oral health literacy. The American Academy of Pediatric Dentistry is a proud partner with the Ad Council and distinguished members of the *Partnership for Healthy Mouths, Healthy Lives* coalition that is about to launch a 3-year oral health literacy campaign. The Ad Council, known for such iconic public service advertising campaigns as Smokey the Bear “Only You Can Prevent Forest Fires” and McGruff the Crime Dog’s “Take A Bite Out Of Crime”, will conduct a national campaign to improve children’s oral health. The goal of the 3-year campaign will be to raise awareness and educate parents and caregivers about the value of good oral health for their children and how it can be achieved. Additionally, the AAPD has produced oral health informational resources such as brochures and videos that are available to anyone at no cost through our Web site.⁵

AAPD members have contributed to the development of statewide initiatives that have increased access to care. An excellent example of this is the Access to Baby and Child Dentistry (ABCD) program in Washington State. A pediatric dentist in each ABCD county or region—or a general dentist in areas without a pediatric dentist—has been selected and trained by the University of Washington to identify, recruit, train and mentor local dentists for the program. These dental champions are essential partners in ensuring that dentists are well-trained and valued partners in meeting the needs of low-income young children in their communities. Almost 1,600 dentists, dental students and pediatric dental residents have been trained since 1995 to provide ABCD’s early pediatric dental techniques and preventive services to young children across Washington State. ABCD providers receive enhanced Medicaid reimbursement for providing family oral health education and selected preventive procedures, including oral evaluation, fluoride varnish application, and certain restorative procedures.⁶ AAPD vice president Dr. Joel Berg was instrumental in the development of this program.

Additional examples of successful State initiatives include Into the Mouths of Babes in North Carolina⁷ and the Michigan Healthy Kids Dental⁸ and Points of Light programs.⁹ Healthy Kids Dental is available to Medicaid-eligible children in 65 Michigan counties, has over 300,000 enrollees. Nearly 91 percent of dentists who treat children in those counties participate in HKD.

Pediatric dentists care for our country’s medically fragile children. Pediatric dentists often treat patients who present special challenges related to their age, behavior, medical status, developmental disabilities, intellectual limitations, or special needs. Caries, periodontal diseases, and other oral conditions, if left untreated, can lead to pain, infection, and loss of function.^{10 11 12 13} Children with significant childhood illnesses like cancer, heart disease, and craniofacial abnormalities have treatment compromised by poor oral health. The role of the pediatric dentist in private practice and in the Nation’s children’s hospitals is to provide dental care to allow life-saving treatment for these children. This is why in addition to the title VII primary care dental training program, the AAPD also supports continuation of Children’s Hospitals GME funding.

The AAPD recognizes the disparities in oral health across ethnic minorities and low-income children, and applauds the subcommittee for shining a spotlight on the issue. The AAPD believes that every child deserves a healthy start on life, but when it comes to oral health, many children face significant challenges. Young children in low-income families tend to have higher rates of tooth decay and have greater difficulty accessing ongoing dental care. Tooth decay is the most common chronic childhood disease—five times more common than asthma. According to data collected for CMS’s Early Periodic and Screening, Diagnostic and Treatment (EPSDT) benefit, only about 38 percent of Medicaid-eligible children received a dental service in 2008, below the Healthy People 2010 goal of 56 percent of children having a dental visit within a year. This is reflected in the October 2010 CDC Fact Sheet, *Medicaid/CHIP Oral Health Services*, which states,

“Despite considerable progress in pediatric oral health care achieved in recent years, tooth decay remains one of the most preventable common chronic diseases of childhood. Tooth decay causes significant pain, loss of school days and may lead to infections and even death.”

More than one-third (36.8 percent) of poor children ages 2 to 9 have one or more untreated decayed primary teeth, compared to 17.3 percent of non-poor children. Additionally:

- Uninsured children are half as likely as insured children to receive dental care.
- Untreated dental decay afflicts one-fourth of children entering kindergarten in the United States.

- Low-income and minority children have more dental cavities than other children.
- Less than one of every five poor children enrolled in Medicaid receives preventive dental services in a given year, even though Medicaid provides dental coverage for enrolled children.¹⁴

A study by Larson and Halfon,¹⁵ using a large national sample, confirms that those who suffer the most from disease, including dental caries, have a host of often intractable social issues that would make consistent provision of established preventive services, by any dental provider, difficult and in some cases impossible.

A healthy mouth contributes to good overall health. Associations have been found between oral infections and diabetes, heart disease, stroke, and low-birth weight babies. Poor dental health damages children, affecting their development, school performance and behavior. In extreme cases, poor dental health and its treatment can lead to serious disability and even death. In finding access to care and managing chronic pain and its consequences, families experience a diminished quality of life.¹⁶

The dental home provides the best dental care. Research indicates that the oral health care of children is best managed within the context of a dental office, or “dental home.” According to the AAPD *Policy on the Dental Home*,

“The dental home is inclusive of all aspects of oral health that result from the interaction of the patient, parents, non-dental professionals, and dental professionals. Establishment of the dental home is initiated by the identification and interaction of these individuals, resulting in a heightened awareness of all issues impacting the patient’s oral health.”¹⁷

A dental home:

- Is an ongoing relationship between the patient and the dentist or dental team that is coordinated/supervised by a dentist.
- Provides comprehensive, coordinated, oral health care that is continuously accessible and family-centered.
- Is an approach to assuring that all children have access to preventative and restorative oral health care.

The benefit of dental services delivered within the context of a dental home is highlighted by Drs. Paul Casamassimo and Art Nowak in the *Journal of the American Dental Association*:

“Children who have a dental home are more likely to receive appropriate preventive and routine oral health care. Referral by the primary care physician or health provider has been recommended, based on risk assessment, as early as 6 months of age, 6 months after the first tooth erupts, and no later than 12 months of age. Furthermore, subsequent periodicity of reappointment is based upon risk assessment. This provides time-critical opportunities to implement preventive health practices and reduce the child’s risk of preventable dental/oral disease.”¹⁸

Pediatric dentists provide quality dental care with a high level of efficiency. Pediatric dentists, on average, spend approximately 92 percent of their time in the office treating patients.¹⁹ In-office visits per pediatric dentist average **3.9 visits per hour, 123.9 visits per week and 5,794.3 visits per year** (3.0 patients per hour, 93.4 patients per week, and 4,395.9 patients per year excluding hygiene visits).²⁰ This compares quite favorably with the full-time dental therapist from Minnesota, who testified before the subcommittee that she only sees anywhere from 6–10 patients a day.²¹

The AAPD has long advocated for effective dental Medicaid programs. Medicaid dental programs that reimburse at market-based rates will succeed in meeting children’s oral health needs. The goal is to obtain high levels of provider participation and patient utilization, with an increased focus on early intervention and prevention. As noted above, pediatric dentists have even gone so far as to support litigation against State Medicaid dental programs that are not meeting Federal requirements for access. The AAPD believes the Federal Government can do a great deal to assist the States in improving their programs by supporting:

1. The formation of public-private partnerships at the State level with Federal grants, with CMS making the promotion of such partnerships a high priority.

States that have been most successful in participation by dentists and utilization by patients have one thing in common—their efforts began with a public-private partnership. These partnerships have addressed the specific barriers to access in each State’s program and, ultimately, to improvement in access to dental services for enrolled children and adults. This was critical to the success of the ABCD pro-

gram in Washington State that was noted above, which involved a collaboration included the Washington State Dental Association, the University of Washington School of Dentistry, the Washington Dental Service Foundation, local health jurisdictions, and others. *Since its inception in 1995, ABCD has more than doubled the percentage of Medicaid-enrolled babies, toddlers and preschoolers who receive dental care in Washington State—to more than 4 out of 10 children today.*²²

2. Initiatives to bring many more private sector dentists into the dental Medicaid program, such as an enhanced Federal medical assistance percentage (FMAP) to States that make needed changes to their dental Medicaid programs as provided in the “Essential Oral Health Care Act of 2009” H.R. 2220. This would result in much higher utilization and the formation of dental homes for a great many more Medicaid beneficiaries.

Over 90 percent of all practicing dentists are in the private sector and—unlike medicine—over 80 percent of dentists are primary care providers. Efforts to improve access must include initiatives designed to address the barriers to bringing more of these dentists into the Medicaid program if access is to improve. All practices, including private dental practices, must have adequate funding to remain viable. Reports issued by the U.S. General Accounting Office to Congress in 2000^{23 24} noted that Medicaid payment rates often were well below dentists’ prevailing fees and that “as expected payment rates that are closer to dentists’ full charges appear to result in some improvement in service use.” Beginning in the late 1990s, several States moved to increase Medicaid reimbursement levels to considerably higher levels consistent with the market-based approach advocated during the National Governors Association Policy Academies. Subsequent evaluations suggest that Medicaid payments that approximate prevailing private sector market fees do result in significant increased dentist participation in Medicaid. States should be given the option of receiving enhanced Federal matching funds if the State chooses to redesign its plan in a manner that:

- Pays dentists market rate fees;
- Eliminates administrative barriers;
- Ensures there are enough dentists signed up willing to provide care; and
- Educates caregivers, such as parents and guardians, on the importance of seeking care.

3. Recommendations to improve CMS oversight of the dental Medicaid programs.

The AAPD recommends that there should be a requirement that dentist provider organizations such as the AAPD are represented on the CMS Technical Advisory Group on dental issues. This is a common practice for private dental insurers, and we believe that CMS needs input from groups that represent the providers in the field who are actually providing care.

The AAPD is also concerned that stagnant Medicaid reimbursement rates, sometimes a decade without increase, threaten safety net programs that depend upon a mix of Medicaid patients to allow them to treat the uninsured. Real costs for these government and non-profit clinics in many cases have increased at a rate that makes their survival doubtful.

While it is always a last resort, in support of children pediatric dentists have been closely involved with litigation against State Medicaid programs. Settlements in the States of Connecticut and Texas resulted in vastly improved Medicaid dental programs, with significant increases in provider participation and patient utilization. There is currently a pending lawsuit in Florida—still in trial—that was filed in 2005 by Florida Academy of Pediatrics and Florida Academy of Pediatric Dentistry.

Expanding the reach of the current dental workforce: the Expanded Function Dental Assistant (EFDA) Model allows for increased access while maintaining the integrity of the dental home. The AAPD advocates the use of EFDAs to increase the ability of the dental office to serve populations who have difficulties in accessing dental care. This will require a change in the dental practice act in many States. An EFDA is a dental assistant or dental hygienist who receives additional education to enable them to perform **reversible**, intraoral procedures, and additional tasks (expanded duties or extended duties), services or capacities, often including direct patient care services, which may be legally delegated by a licensed dentist under the supervision of a licensed dentist. Since the EFDA practices under the supervision of a licensed dentist, within the dental home, children are ensured access to comprehensive care, including restorative services to eliminate pain and restore function. Additionally, research suggests that the use of EFDAs can increase the capacity of the dental office. Beazoglou, et al., in an economic analysis of EFDAs in Colorado, concluded that private general dental practices can substantially increase gross billings, patient

visits, value-added, efficiency and practice net income with the delegation of more duties to auxiliaries.²⁵

Furthermore, the dental team can be expanded to include EFDAs who go into the community to provide education and coordination of oral health services. Utilizing EFDAs to improve oral health literacy could decrease individuals' risk for oral diseases and mitigate a later need for more extensive and expensive therapeutic services. Increased access to screening, preventive services, parent and caregiver education within the dental home provided by EFDAs, will improve the oral health of high risk populations and result in a higher percentage of Medicaid-enrolled children receiving preventive, diagnostic and treatment dental services. Current research indicates that:

(a) Provision of oral health outreach and case management to vulnerable populations will increase access to and utilization of dental services at an earlier stage in the disease process and decrease utilization of emergency rooms for treatment of oral problems.

(b) On-site oral hygiene instruction (for students and parents) and case management will increase positive oral habits, leading to a decrease in the need for expensive treatment services.

(c) Increased early access and positive oral habits will result in lower costs overall.

The EFDA model utilizes a multi-level, multidimensional approach and employs strategies that have been effective in improving health and lowering costs. The following have shown significant promise to meet the desired outcomes:

- Getting children into care early—preferably by the age of 1 year.

A study in the journal *Pediatrics* found that preschool-aged, Medicaid-enrolled children who had an early preventive dental visit were more likely to use subsequent preventive services and experience lower dentally related costs. The average dentally related costs per child according to age at the first preventive visit were as follows: before age 1, \$262; age 1 to 2, \$339; age 2 to 3, \$449; age 3 to 4, \$492; age 4 to 5, \$546.²⁶

- Enabling providers to incorporate additional parent education and empowerment activities into their practices, using proven methods of health literacy.

An increase in early prevention and oral hygiene instruction provided to children and parents/caregivers would substantially reduce the overall cost to the system that results from delayed treatment and lack of knowledge by vulnerable populations of good oral hygiene practices. This hypothesis is supported by a study of school-based dental programs in 13 States conducted by Bailit, et al. Review of revenues and expenses in programs where services were provided by hygienists with support staff found that screening and preventive services in schools with portable equipment were financially feasible in States when the ratio of Medicaid fees is 60.5 percent of mean national fees.²⁷

- Incorporating case management into routine dental care, based on both socioeconomic and biologic caries risk.

Kids Get Care in King County, WA, links every family with a case manager who assists the family with medical and dental needs. These results point to the cost-effectiveness of providing (and paying for) case management services. The 16 practices participating in the first year of the Children's Preventive Health Care Collaborative (CPHC) in 2005 achieved an aggregate 91 percent increase in the percentage of 1- to 4-year-old Medicaid patients receiving fluoride varnishes during a well-child visit. Fluoride varnish has been demonstrated to reduce caries by 38 percent.²⁸ According to the Washington State Department of Health, dental care is the most frequent cause for treatment in the operating rooms of Children's Hospital and Regional Medical Center. Hospital treatment of this sort can cost \$4,500 per child. By contrast, the cost of three fluoride varnish applications per year per child is approximately \$40.

CONCLUSION

The AAPD strongly believes the recommendations above would have the most positive impact on improving access to children's oral health care. Dr. Edelstein's testimony before the subcommittee also raised important issues that must be considered in the implementation of pediatric oral health coverage in State health insurance exchanges under the "essential health benefits" provision of the Affordable Care Act (ACA). Written testimony of the American Dental Association strongly refutes the argument that creating thousands of dental therapists is likely to have a

positive impact on access. The AAPD will continue its efforts to promote a dental home for all children, starting with the first dental visit by age one.

More information is available about the AAPD's clinical guidelines, and the AAPD *Policy on Workforce Issues and Delivery of Oral Health Care Services in a Dental Home*, is available on our Web site.²⁹

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PREPARED STATEMENT OF THE AMERICAN DENTAL ASSOCIATION (ADA)

The not-for-profit American Dental Association (ADA) is the Nation's largest dental organization, representing more than 156,000 dentist members. The premier source of oral health information, the ADA has advocated for the public's health and promoted the art and science of dentistry since 1859.¹

Most Americans have access to the best oral health care in the world and, as a result, enjoy excellent oral health. But tens of millions still do not, owing to such factors as poverty, geography, lack of oral health education, language or cultural barriers, fear of dental care and the belief that people who are not in pain do not need dental care. Lack of oral health care is especially troubling in light of the increasing body of knowledge of the interrelationships between oral health and overall health.

Official recognition of the important role oral health plays in an individual's overall health continues to grow, as for the first time in the 30-year history of the Department of Health and Human Services' "Healthy People" series, Healthy People 2020 has recognized oral health as a leading health indicator in the Nation's overall health.

A number of States are working to improve access to dental services for many underserved. For example, according to information included in the Pew Center on the States May 2011 report, Vermont has steadily increased utilization among its pediatric Medicaid population from 48.9 percent in 2000 to 57.3 percent in 2009. This approaches private sector utilization rates of between 60 and 65 percent. Data on the number of third graders in the State with dental sealants indicates a rate of 66.1 percent.² In addition, only 2.5 percent of Vermont's residents live in a dental health professional shortage area. The report indicates that it will only take one additional dentist to remove the shortage designation in Vermont.³

The ADA believes that all Americans deserve good oral health and oral care delivered by fully trained dentists. Early diagnosis, preventive treatments and early intervention can prevent or halt the progress of most oral diseases—conditions that when left untreated, can have painful, disfiguring and lasting negative health consequences.

It is critical to understand that addressing only one or even a few of the numerous barriers to care is the policy equivalent of bailing a very leaky boat. Scattershot efforts can provide some measure of relief among some populations for some time. But ultimately, we as a nation must muster the political will to address all barriers to care. Not doing so is a recipe for repeating past failures and missing opportunities to effect lasting, positive change.

THE MANY BARRIERS TO OPTIMUM ORAL HEALTH IN AMERICA

Geography

Studies conducted by the ADA and the American Dental Education Association indicate that the number of dental schools and graduates will increase steadily through 2030 and that the number of professionally active dentists will increase from its current level of approximately 180,000 to as many as 200,000 over the same period. (Although many factors can affect so large an undertaking as opening a den-

¹The ADA's state-of-the-art research facilities develop and test dental products and materials that have advanced the practice of dentistry and made the patient experience more positive. The ADA Seal of Acceptance long has been a valuable and respected guide to consumer dental care products. The monthly *Journal of the American Dental Association (JADA)* is the ADA's flagship publication and the best-read scientific journal in dentistry.

²*The State of Children's Dental Health: Making Coverage Matter*, Pew Center on the States, May 2011, p. 21–22.

³*Ibid*, p. 23.

tal school, some observers estimate that there will be as many as 20 new schools by 2020). Further, the studies indicate that the age levels of the dental workforce will even out, in part because the dental population of baby boomers is retiring at later ages than its predecessors. This means that the available supply of active dentists will not suffer the major reduction that is commonly predicted.

Dentist workforce *size* is not a problem now, nor is it likely to be in the predictable future. The real problem is where the dentists are in relation to underserved populations. Put simply, the ADA believes that access disparities can be greatly reduced by a combination of getting dentists to the people and getting people to the dentists. Like any other economic sector, health care is market-driven. This is especially true with dentistry, whose private practice model has held up so well because of its proven ability to prevent disease and, when disease occurs, intervene early with cost-effective treatment. In the economic sense, the populations in the most common underserved settings—remote rural areas, Native American communities and inner cities—cannot support a dental practice because no one is paying adequately for their care. Even many children who ostensibly are covered by federally or State-mandated programs live too far away from dentists who participate in the programs and face transportation barriers. For adults the problem is compounded by limited or non-existent coverage under Medicaid and availability of participating providers.

Several proven models exist to alleviate geographic barriers, and others are being tested. The National Health Service Corps, the Indian Health Service and the network of Federally Qualified Health Centers use various combinations of incentives to place dentists in underserved areas, including student loan repayment. Some States also offer tax incentives for practitioners working in underserved areas. Some dental programs join forces with various school or social service entities to help address the need to provide transportation and other support services to help patients keep appointments.

Education, Language and Culture

The more educated a population group, the greater the likelihood of its members having a high degree of oral health literacy. They know how to take care of their families' teeth and gums, and they seek (and can afford) regular preventive dental care. They know whether their community water system is fluoridated and how to compensate for nonfluoridated water with supplements or topical applications. They brush regularly with fluoridated toothpaste and use floss.

But too many others simply don't know about basic and affordable measures for preventing disease. In some cases this relates to lack of education. Many others have limited English proficiency or may come from countries and cultures with much lower standards of oral health than exist here. Some may not be comfortable interacting with people perceived as authorities. Key to breaking down these barriers is gaining trust, which can be accomplished through intermediaries from the same cultures as the target populations or by providing oral health education to schoolchildren who then can share what they learn with older family members.

ADDRESSING THE BARRIERS TO ORAL HEALTH

Public Health Interventions

Efforts that emphasize oral health literacy and disease prevention, such as community water fluoridation, sealant initiatives and school-linked health education and care programs are critical for improving the public's health, especially over the long term. Fluoridation, along with other preventive initiatives such as dental sealant and fluoride varnish programs, has led to great reductions in tooth decay.

The ADA has been a leader in health literacy, specifically in dentistry, working alongside private and public colleagues in medicine, pharmacy, nursing and public health to advance health literacy improvement. The ADA's National Advisory Committee on Health Literacy in Dentistry is a group of national and international health communication and literacy experts who guide the Association's efforts in this area. The committee has developed a 5-year strategic action plan, focusing on education and training, advocacy, research, dental practice and coalition-building. One of the Association's 3-year strategic goals is to continue to be "the trusted resource for oral health information that will help people be good stewards of their own health." The ADA's efforts are noted in the Health Literacy Action Plan created by the Department of Health and Human Services.

The Centers for Disease Control and Prevention (CDC) has named fluoridation one of ten most significant public health achievements of the past century. The ADA actively supports fluoridation as part of its mission to improve the public's health and dentists strongly believe community water fluoridation should be a cornerstone

of a broad-based comprehensive integrated strategy for the prevention of tooth decay.

The most recent CDC data indicates that more than 72 percent of community water sources in the United States are fluoridated. Healthy People 2020 calls for nearly 80 percent of the population accessing public water supplies to receive the benefits of fluoridation by the end of this decade. Fluoridation is a public health measure that saves money. A study conducted in 2006 concluded that the New York Medicaid program spent nearly \$24.00 less in treatment costs per child in predominantly fluoridated counties versus counties with little fluoridation.

Safety Net Delivery Systems

Federally Qualified Health Centers

Federal law requires all Federally Qualified Health Centers (FQHCs), as a condition of receiving Federal funding, to demonstrate that they will provide dental services to the population served by the facility either onsite or through a contractual arrangement. The demand for dental services is also growing and efforts have been underway to provide support for FQHCs to meet these needs.

The ADA is collaborating with the National Association of Community Health Centers (NACHC) to increase education among our respective members on the opportunities that exist for FQHCs to provide dental services, including the ability of FQHCs to contract with private dentists in the community to serve their patients. The ADA has also offered an educational session during its annual session for members entitled *The ABCs of FQHCs*. This educational session has been highly successful and the 2012 session will be the fourth year it is offered.

The National Network for Oral Health Access (NNOHA), the organization that represents community health center dentists, has increased its efforts to provide health centers with technical assistance through a cooperative agreement with HRSA's Bureau of Primary Health Care. Through this agreement, NNOHA recently completed webinars on the following topics aimed at improving both leadership and clinical management of health center dental programs: FQHC dental program productivity and financial impact; risk management for health center dental providers; financial management of health center oral health programs; and how to become an outstanding dental director. NNOHA also has multiple dental practice management modules available for FQHC dental programs.

Indirectly, the ADA is a major supporter of NNOHA:

- Senior ADA staff serves on their board of directors as a liaison between private practitioners and those dentists who practice within health centers;
- The ADA provides fiscal support for the National Primary Oral Health Conference, which provides both leadership and clinical training for health center dentists; and
- NNOHA has been invited to participate in the Dental Quality Alliance and other activities involving the ADA and other stakeholders in the dental community.

The ADA promotes opportunities for dentists in FQHCs as participants in the National Health Service Corps loan repayment program through outreach with the American Student Dental Association. This includes part-time opportunities for dentists within health centers, which helps to promote an interdisciplinary approach to patient care while allowing dentists to build a private practice and secure loan repayment incentives.

FQHCs and other health centers may be limited in terms of their ability to hire a full-time dental director and their ability to set up adequate numbers of dental operatories. The ADA, NNOHA, NACHC, HRSA and Safety-Net Solutions continue to strategize on how best to provide technical assistance to community health centers. The ADA continues to promote the opportunities that exist within community health centers to its membership.

Dental Schools and Dental Residency Programs

Dental schools can also be instrumental in improving the availability of dental services for communities. Their clinics and offsite training programs provide needed care to patients who otherwise could not afford it. The possibility exists that some dental school clinical practices could expand these services, using their medical school counterparts' faculty practice model, increasing the numbers of patients served, creating greater revenues for the schools, and providing greater clinical training opportunities for students and residents. Ninety-one percent of schools now require students to complete a rotation in a clinic or other underserved community setting. In 2008 through 2009, 57 dental schools reported over 260-average hours of community-based clinical care provided by their students as part of their dental education.

Dental schools are employing a number of creative approaches to provide community outreach and care for the underserved. One such example is the collaboration of the NYU College of Dentistry and the Henry Schein Cares Foundation, which places dental students, faculty, residents and hygienists in clinical settings operated by Caring Hands of Maine (one of a number of domestic and international sites covered by the program), in an effort to establish sustainable oral health systems. Programs like this also offer the ancillary benefit of bringing students into direct contact with underserved individuals living in the community who have a demonstrable need for oral health care and the real impact they can have in providing that care as practicing dentists. Here again, any such training must be conducted under the appropriate supervision of fully trained dentists, for the benefit of both patients and students.

Hospital Dental Residency programs (Title VII of the Public Health Service Act) provide a disproportionate level of care to the underserved population. With funding for post-doctoral training in general, pediatric and public health dentistry, the program has helped create over 560 new general dentist positions in the past 25 years (representing 80 percent of such growth) and 200 new pediatric dentist positions in the past 15 years. In addition, research shows that optimal funding for title VII dental programs will produce graduates that are more likely to treat at-risk populations in their practices.

Models for Change in the States

Even under chronic funding constriction, imaginative people have maximized available resources and leveraged natural allies to dramatically improve the abilities of existing programs and systems to deliver care where it is most needed. Just as no two patients are alike, no two States are alike when it comes to ensuring that the greatest possible number of their residents receives the dental care they deserve. The barriers to oral health among the 50 States are just as varied as the maladies that can send a patient to the dentist in the first place. They range from a lack of dental insurance, to cultural and language barriers, to underfunded State programs, to a lack of understanding about the importance of oral health as part of one's overall health.

In the face of this complex challenge, there is no simple, one-size-fits-all solution. Solutions that would help alleviate barriers to care in New Mexico, with its large Native American population, differ from those appropriate to California with its sizable urban and ethnically diverse communities. That's why, as doctors of oral health, dentists have been working closely for years with State and community leaders to address challenges in ways that are most suitable to address the particular barriers and nature of the underserved populations in their respective States. And with that approach we have seen success in several States:

Connecticut

In 2006, the Connecticut State Dental Society and a coalition of oral health organizations successfully convinced the State legislature to increase Medicaid's commitment to children's dental care and guarantee a dedicated dental administrator, outside the larger medical program administrator, commonly known as a carve-out. It didn't take long for the results of this legislative win to become evident. Prior to the new legislation, roughly 150 dentists participated in Medicaid; today more than 1,300 dentists now see children enrolled in Medicaid. Perhaps more telling is the dramatic increase in the number of children actually receiving care. In the years following the new legislation, 22,000 more children in Connecticut received dental treatment and 32,000 more obtained preventive care as part of their Medicaid plans. And as of March 2011, all child participants in Medicaid have access to at least two oral health care providers within a 20 mile radius. Maximum wait time for non-emergency appointments is now 20 days or less; children needing emergency appointments wait no longer than 24 hours.

The upshot has been that children are no longer waiting in line for care at charitable events like Connecticut Missions of Mercy, where dentists and their teams provide free services to thousands of people who face various barriers in accessing the dental delivery system. In fact, the State's dental program manager has commented that Connecticut no longer has a dental access problem, but rather one of utilization. And addressing utilization problems calls for better oral health education and the provision of services to help people access available care.

Arizona

More than 2,000 miles away in the southwest, the dental profession has been working with Native American communities to address their unique oral health challenges. As part of this ongoing work, in April 2011, the Arizona Dental Association organized the Native American Oral Health Summit, which brought together

tribal leaders, members of the dental profession, the Indian Health Service (IHS), and other community and public health leaders. Summit participants collaboratively developed several common goals, including increased funding for oral health projects, improved application of IHS resources and the creation of an education and workforce pipeline that encourages Native American students to pursue dental careers. Following this successful effort, State dental associations and Tribal partners are organizing similar summits in other Native American communities across the country to develop solutions that address local needs. In addition, dentists in Arizona were instrumental in the creation of a pilot program that provides free in-school dental screenings, so that tooth decay and other oral disease in children can be identified and treated early. In 2011, the Arizona Dental Association Foundation was awarded a grant by the Dentaquest Foundation, one of 20 across the country, to develop an American Indian oral health coalition in the State. The goal of these efforts is to address the challenges this population faces.

Michigan

Michigan's Healthy Kids Dental (HKD) Medicaid demonstration program is a partnership between a State Medicaid program and a commercial dental plan, with the plan managing the dental benefit according to the same standard procedures and payment mechanisms it uses in its private plans. The proportion of Medicaid eligible children who saw a dentist at least once increased from 32 percent to 44 percent in the pilot program's first year. It also cut the number of counties with either no dentist or no dentist able to accept new Medicaid patients in half—from 19 to 10. This model demonstrates how contracting with a single commercial entity that: (1) has a strong existing dental network; (2) offers competitive market-based reimbursement and (3) streamlines administration to mirror the private sector, can substantially improve access to care for Medicaid beneficiaries. In each succeeding year from program inception in 2000 through 2007, the proportion of the children enrolled for 12 months in a calendar year with at least one dental visit has continued to increase, with the access levels approaching 70 percent in children 7 through 10 years old, by 2007 for HKD counties. But the dental community recognizes that more can be done and is working to expand the HKD program to additional counties, which includes the major urban areas of the State.

Tennessee

Tennessee's TennCare program, which was established in 1994, was the first attempt by a State to move its entire Medicaid population into a statewide managed-care system. The impact on dental services was disastrous. The number of participating providers dwindled from its 1984 level of more than 1,700 down to 386 general and specialist dentists available to treat the more than 600,000 TennCare eligible children. In 2002, the legislature enacted a statutory carve-out of dental services, which mandated a contract arrangement between the State and a private dental carrier to administer benefits for children (under age 21). The State retained control of reimbursement rates and increased them to market-based levels.

The new rate structure, in combination with administrative reforms, patient case management strategies and a requirement that the carrier maintain an adequate provider network, has substantially improved TennCare's provision of dental services. In just 2 years, the utilization rate among eligible beneficiaries increased from 24 percent to 47 percent. Though there have not been significant increases since the carve out was done, as of January 2012, over 950 dentists were participating in TennCare.

Alabama

Alabama reformed its State-administered Medicaid dental program in 2000 to reimburse dentists at rates equivalent to those paid by commercial insurers. (The program still reimburses dentists at year 2000 rates.) The changes included creation of the Smile Alabama! initiative, which encompassed administrative reforms, a case management program, and increased outreach to both patients and dentists. As a result of the Smile Alabama! initiative, there has been a 216 percent increase (from 151 to 477) in the number of dentists who see more than 100 Medicaid patients a year, while the number of counties with one or no Medicaid dental provider had declined from 19 to 3 by September 2009. The effort resulted in an 84.3 percent increase in dental utilization, from 25 percent (103,630) of eligible children in fiscal year 2001 to 45 percent (190,968) of eligible children in fiscal year 2007.

Vermont

This example, the smallest in scale, is in many ways the most intriguing, embodying a diverse group of local entities crafting a solution uniquely suited to local needs. In 2001, in Brattleboro, VT, Head Start, the State health department, school

officials and hospital administrators collaboratively established a fee-for-service, for-profit dental center to address the needs of the underserved in a rural community. The organizers raised \$450,000 in 3 months and built a three-chair, state-of-the-art facility with sufficient infrastructure to expand to five chairs. Now in its tenth year, the Estey Dental Center serves both private paying and public assistance patients and pays a percentage of non-Medicaid revenues to the non-profit contracting entity (the community partners). In its first 2 years of operation, the clinic cleared a huge backlog of children with acute and chronic dental needs and began to increase adult utilization as well.

Maryland and Ohio

Dentists in Maryland have secured an expansion of dental Medicaid, bringing care within reach for more of the State's citizens. After the tragic death of Deamonte Driver, the Maryland Department of Health and Mental Hygiene convened a Dental Action Committee (DAC). The DAC created a dental action plan, including recommendations such as increasing reimbursement levels, developing a culturally appropriate oral health message for the target population and training dental and medical providers to provide oral health risk assessments, among others. According to data reported to CMS, dentists' participation increased from 743 in July 2008 to 902 in February 2010 and utilization rates increased for children enrolled in the program from 31 percent in 2007 to 36 percent in 2008.

Dentists in Ohio have advocated successfully for the State's local health departments to purchase portable dental equipment, so that dentists and other dental professionals can reach patients in nursing homes, senior centers, schools, clinics and other community centers to provide onsite dental care for underserved populations. Additionally, dentists supported the creation of the Ohio Dentist Loan Repayment Program. The program provides loan repayments to dentists that provide care in designated underserved areas, as defined by the program, for a minimum of 40 hours per week to Medicaid-eligible individuals and others without regard to a patient's ability to pay. Funding for the program comes from a portion of dentists' licensure fees.

These diverse initiatives share common elements. All of them utilized existing workforce models. They wrought significant, positive change through relatively minor funding increases combined with dramatic changes in administration. Each made it possible for more patients to receive care from the same population of dentists that existed before the programs were launched.

Alternative Workforce Solutions

Dental Mid-level Models

Multiple groups have offered models intended to provide clinical services—including surgery—to underserved populations. They are largely targeted toward serving people in remote rural areas, with the justification being that there are not and never will be sufficient dentists able to practice near enough to those areas to serve their residents. To a lesser extent, backers of these models also claim that they will care for other underserved populations, including people in inner cities and Native American tribal lands.

The designers of these models often cite various dental therapist programs in other countries in which non-dentists perform such surgical procedures as "simple" extractions, restorations and even pulpotomies (root canals on baby teeth).

Both of these suppositions fail to withstand scrutiny.

- The assertion that no dentists will serve these populations risks becoming a self-fulfilling prophecy. Advocacy and Federal finances directed toward experimental programs in which non-dentists perform surgical procedures undoubtedly will sap resources away from proven programs—such as the National Health Service Corps, Indian Health Service, the Public Health Service, loan forgiveness, tax incentives, and public/private partnerships, all of which are proven to place dentists where they are most needed.

- Claims that the efficacy of therapists has been "proven" in other countries are simply deceptive. The mid-level programs in these countries differ so dramatically in scope of practice, populations served and degree of dentist supervision, that referring to them en masse is misleading at best. In fact, if you've seen one foreign mid-level program, you've seen one foreign mid-level program.

- Further, these claims largely lack longitudinal clinical assessments of health outcomes. *We know of no study comparing any improvements in oral health among targeted populations to the potential outcomes had the same resources been directed to providing these patients with care from dentists.* They are touted as brilliant successes with very little empirical evidence to support those claims. In fact, some evidence shows that countries like New Zealand, Great Britain and Australia (who

allow dental mid-levels to deliver surgical procedures to children) have poorer oral health index scores than we have here in the United States.

Dental mid-level models often are compared to physician assistants or nurse practitioners, generally omitting the significant differences among those models. Physician assistants and nurse practitioners require up to 6 years of post-high school education, not the 2 years or less suggested for many dental therapist models. Surgical procedures are not part of the scope of practice of medical mid-levels, in stark contrast to the proposed dental mid-level providers.

Significant differences also are present among various dental mid-level models, most notably in their proposed scopes of practice and degree of supervision. They share, however, a critical attribute that the ADA opposes unequivocally: *Allowing non-dentists to perform surgical procedures, often with little or no direct supervision by fully trained dentists.*

Three mid-level models dominate the current discussion of these personnel.

Alaska DHAT Model

The Alaska Dental Health Aide Therapist (DHAT) model was designed to mirror its New Zealand counterpart. At its inception, program participants were even trained in New Zealand, in part because the program's authors could not identify a U.S. dental school that would participate in training non-dentists to perform surgical procedures. The program has since worked out a training curriculum with the University of Washington (although it is worth noting that the relationship is with the University's medical school and not its dental school). Now in its fifth year, the Alaska DHAT program is fielding a modest number of therapists who are providing care.

In a case study released in October 2010, the W.K. Kellogg Foundation declared the program a resounding success, even as the study's principal author admitted that the evaluation did not assess the overall impact of therapists' work. The study also failed to address the economic basis for or sustainability of the DHAT model.

Kellogg's release of this study was a prelude to its larger purpose—the rollout of plans to create DHAT programs in five additional States: Kansas, New Mexico, Ohio, Vermont and Washington. However, the Alaska program benefited from the Federal Government's power of preemption, enabling the DHAT program to circumvent the jurisdiction of the State's legislature, courts and board of dentistry. Kellogg presumably must convince policymakers in the five targeted States, each of them with unique rules and policies governing education and health care, to allow DHAT programs to begin. The foundation has committed \$16 million to setting up the program. It is unclear how much (if not all) of that sum will go toward the political activities needed to legalize DHAT practice and how much will be devoted to actually launching educational and training programs.

Advanced Dental Hygiene Practitioner

The American Dental Hygiene Association (ADHA) has for some years advocated the creation of an Advanced Dental Hygiene Practitioner (ADHP), a dental hygienist with a bachelor's degree who, after earning a 2-year Master's degree, would be allowed to practice independent of a dentist's supervision. In addition to the existing scope of hygiene practice, ADHPs would diagnose oral disease, create treatment plans and perform "limited restorative procedures," including preparing and placing restorations, extractions and pulpotomies. Like the DHAT, the ADHP is expected to distinguish between complicated and uncomplicated treatments and refer the former to a fully trained dentist. Here again, the ADHA cites the use of various mid-levels in 40 countries as evidence that a mid-level model will work in the United States, without acknowledging the great variations in training and scope of practice among those providers.

Dental Therapists in Minnesota

In 2009, the Minnesota legislature, facing formidable pressure to enact an ADHP model, opted instead for a compromise worked out with the State's dental school, in which the school will train two levels of dental therapists. Dental therapists would graduate from an education program with either a baccalaureate or a master's degree depending on the student's past academic achievement. Dental therapists would practice under the direct or indirect supervision of a dentist when performing surgical procedures and could perform some non-surgical procedures without the physical presence of a dentist but under a dentist's general supervision. Those qualifying for advanced therapist status must have completed 2,000 hours of practice as a dental therapist, and have graduated from a master's-level advanced dental therapy education program. Advanced dental therapists will then be allowed to perform certain surgical procedures under a dentist's general supervision with a

written collaborative management agreement, that is, without a dentist actually on-site with the therapist.

The models above share some basic flaws.

- The mid-level providers are trained to provide many of the same surgical services that a dentist now provides after only receiving a fraction of the education of a dentist. These models have been proposed to treat the existing underserved communities, who often have the most complex dental needs.
- They overload mid-level providers with more responsibility than they should be expected to bear. Their proponents consistently refer to certain surgical procedures, including extractions, as “simple,” saying that of course more complex cases will be referred to dentists. However, fully trained and experienced dentists argue that mid-levels’ training cannot adequately prepare them to distinguish between “simple” and “complex” cases. In fact, even fully trained dentists do not conclusively pronounce a procedure as simple until it has been *successfully* completed.
- A second weakness rarely mentioned is the mid-level’s questionable ability to distinguish between teeth that cannot be saved and should be extracted and those that could be saved by restorative methods beyond the mid-level’s training. If your only tool is a hammer, every problem looks like a nail.
- A greater and broader weakness among proponents of mid-level practitioners is their near-obsessive focus on mid-levels as the ultimate solution to access problems. Differences in opinion about the appropriate scope and supervision of various dental team members aside, arguing so vehemently for any single workforce model, while failing to place equal or even greater emphasis on the numerous other barriers to care is either naive or disingenuous. In some ways, these models are a solution in search of only one part of a problem.

Shifting from the clinical to the policy point of view, we know of no empirical studies of the economic feasibility of dental mid-levels. Proponents of these models either imply or assert that care from these providers will somehow be less expensive than that delivered by dentists, because they will earn less than dentists. We know of no evidence to support this. Compensation is a relatively small percentage of the costs of establishing and maintaining a dental facility. The difference between the salary of a dentist and that of a therapist or advanced hygienist would likely be offset by their lower productivity compared to a fully trained dentist and have a minimal effect on the overall cost of delivering care.

A Different Approach to Augmenting the Dental Team

The ADA also is piloting a new dental position, the Community Dental Health Coordinator (CDHC), but one that represents a completely different philosophy. Modeled on the community health worker, which has proven extraordinarily successful on the medical side, CDHCs will function primarily as oral health educators and providers of limited, mainly preventive clinical services. They help patients navigate the system, including ensuring that the patient clears the red tape that can complicate their receiving the care to which they are entitled, finding dentists, booking appointments and helping to provide critical logistical support such as securing child care, transportation and permission to miss work in order to receive treatment.

The CDHC is based on some of the ADA’s key principles for breaking down barriers to care: education, disease prevention and maximizing the existing system. Rather than focusing strictly on treating disease, the CDHC provides education and preventive services. At its essence, oral health education is prevention at the most effective level. Models that focus exclusively, or almost exclusively, on performing procedures ignore these critical success factors.

In many cases, underserved populations also face cultural barriers. This is nowhere more evident than among Native American communities. For example, in some tribes, the mothers prechew food before giving it to their babies, which vertically transmits bacteria from the mother to the baby. Additionally, increasing numbers of people living throughout the country have limited English proficiency or come from cultures that lack awareness of basic oral hygiene. CDHCs are recruited from these same communities, ideally not just similar communities but the actual communities to which they return and work. This critical factor can minimize and even eliminate these barriers that, though not often associated with access to oral health care, can affect it profoundly.

CONCLUSION

Prevention is essential. A public health model based on the surgical intervention in disease that could have been prevented, *after* that disease has occurred, is a poor model. The Nation will never drill, fill and extract its way to victory over

untreated oral disease. But simple, low-cost measures like sealing kids' teeth, educating families about taking charge of their own oral health, expanding the number of health professionals capable of assessing a child's oral health, and linking dental and medical homes will pay for themselves many times over.

ADA Supports Public Health Intervention and Safety Net Delivery Systems. Public health initiatives such as community water fluoridation, sealant initiatives and school-linked health education and care programs are critical for improving the public's health. The ADA, NNOHA, NACHC, HRSA and Safety-Net Solutions continue to strategize on how best to provide technical assistance to community health centers. The ADA continues to promote the opportunities that exist within community health centers to its membership.

Public-private collaboration at the State level works. Private practice dentists, who comprise over 90 percent of practicing dentists (just over 2 percent of dentists practice in FQHCs), will continue to deliver the hands-on care to most of the population, regardless of payment mechanism. A number of States have demonstrated that even under chronic funding constriction they have been able to improve programs by simplifying program administration, reducing red tape and assisting patients with related, non-clinical needs. Make it easier for the dentists to deliver care and the safety net will address the oral health needs of more patients.

Everyone deserves a dentist. The existing team system of delivering oral health care in America works well for patients in all economic brackets. It does not need to be reinvented. Rather, it needs to be extended to more people. States like Michigan, Connecticut and Tennessee have shown that there are a sufficient number of dentists in the country and that adjusting Medicaid payments can have significant impact to bring them into the already existing system. Creating a separate tier of care for underserved populations will sap resources from solutions that already work, and will do comparatively little to improve the oral health of those in greatest need.

Availability of care alone will not maximize utilization. In too many cases, people are unable or unwilling to take advantage of free or discounted care. Many dentists who treat Medicaid patients must contend with a much greater incidence of missed appointments than they experience with non-Medicaid patients. These missed appointments represent erosion of available treatment time that the system cannot afford to waste. This owes partly to the need for better attention to social or cultural issues, oral health education, and greater support for patients who need help with transportation, child care, permission to miss work or other non-clinical services.

Treating the existing disease without educating the patient is a wasted opportunity, making it likely that the disease will recur. Anyone who enters a dental operator for restorative care should leave that operator with an understanding of how to stay healthy and prevent future disease. Excessive alcohol or sugar consumption can increase the risk of oral disease. Tobacco use in any form increases the risks for gum disease and oral cancer. Educating patients about these risks and how to reduce them should be incorporated into every possible patient encounter.

Silence is the enemy. Let's take the "silent" out of "silent epidemic." Virtually every shortcoming in the safety net has at its root a failure to understand or value oral health. When people, whether lawmakers, the media or the general public, learn about oral health and the consequences of oral disease, their attitudes and priorities change. Awareness is on the rise, but we have far to go before Americans know enough to make the personal and policy decisions that ultimately will create a real safety net, one that prevents oral disease and restores oral health in people who seek healthier and more productive lives.

Dentists will continue to collaborate with policymakers and members of the public health community around the country to craft access solutions that are tailored to local needs and challenges. These include increasing Medicaid funding; preventive measures such as school dental screenings and sealant programs; expanding student loan forgiveness programs to encourage more dentists to practice in underserved areas; and reducing the red tape that sometimes makes it difficult for dentists to provide care through Medicaid or to specific communities, such as Native Americans.

But State and Federal Governments must do their parts, at a minimum maintaining their existing commitments to providing oral health care for the millions of Americans who are most in need, especially children. The dental profession and its allies will continue to lead the fight to break down barriers to oral health for all Americans, and we invite all organizations and individuals who share this goal to join us.

PREPARED STATEMENT OF PAMELA QUINONES, RDH, BS, PRESIDENT, AMERICAN
DENTAL HYGIENISTS' ASSOCIATION (ADHA)

On behalf of the American Dental Hygienists' Association (ADHA), thank you for the opportunity to submit testimony on the "Dental Crisis in America: The Need to Expand Access." ADHA commends the subcommittee for holding a hearing to examine the challenges many Americans face in accessing oral health care. Dental caries (tooth decay) remains the single most common chronic disease of childhood, five times more common than asthma.

According to the Health Resources and Services Administration, nearly 48 million people live in 4,464 federally designated areas without enough dentists.¹ As a result, millions of children and adults suffer unnecessarily, miss school or work and, in rare cases, face life threatening infections from untreated dental decay. To overcome these shortages, the U.S. Government estimates we need an estimated 9,500 new dental practitioners.² Augmenting the dental workforce is an essential element of expanding access to dental care.

ADHA is pleased to participate in the dialog about ways in which oral health access can be improved and the oral health workforce can be optimized to improve the delivery of oral health care services. As the links between individuals' oral health and total health continue to emerge, it becomes increasingly important for stakeholders in oral health to consider ways in which access to care can be increased.

ADHA is the largest national organization representing the professional interests of more than 150,000 licensed dental hygienists across the country. In order to become licensed as a dental hygienist, an individual must graduate from an accredited dental hygiene education program and successfully complete a national written and a State or regional clinical examination. Dental hygienists are primary care providers of oral health services and are licensed in each of the 50 States. Hygienists are committed to improving the Nation's oral health, a fundamental part of overall health and general well-being.

As an organization, ADHA is committed to better oral healthcare for all people and advocates in support of Federal oral health programs, expanding access to care for underserved populations and maximizing coverage for oral health services. ADHA and its State associations actively pursue efforts to increase the public's ability to access oral healthcare services.

ORAL HEALTH IS INTEGRAL TO TOTAL HEALTH AND MOST DENTAL DISEASE
IS PREVENTABLE

It is well-documented that America is in the midst of a health care crisis as over 50 million Americans lack health insurance.³ However, what is often overlooked is another vital statistic: the 130 million people that do not have dental coverage in this country.⁴ The May 2000 report, *Oral Health in America: A Report of the Surgeon General*, brought to light the "silent epidemic" of oral disease, which affects our most vulnerable citizens—poor children, the elderly and many members of racial and ethnic minority groups. The landmark report also confirmed that total health cannot be achieved without optimal oral health.⁵

Research continues to emerge demonstrating the link between oral health and total health. The Centers for Disease Control noted the relationship between periodontal disease and health problems like diabetes, heart disease, and strokes.⁶ The tragic death of 12-year-old Deamonte Driver who died in 2007 as a result of complications from a brain infection that was brought about by an abscessed tooth was an unfortunate demonstration of the impact of untreated oral disease. Just last year, Kyle Willis, a 24-year-old father died from a tooth infection because he couldn't afford the antibiotics he needed, offering a sobering reminder of the importance of oral health and the serious—even fatal—consequences that people without access to dental care suffer. Lack of access to dental care forces too many Americans to enter hospital emergency rooms seeking treatment for preventable dental conditions, which emergency rooms are typically ill-equipped to handle. The Nation lacks an effective dental safety net.

Most oral disease is completely avoidable with proper preventive care; however, in spite of this proven prevention capacity, oral disease rates among children and adults continue to climb.^{7,8} Preventing oral disease can positively impact total health and is also cost-effective. Research indicates that low-income children who have their first preventive dental visit by age one incur dental related costs that are approximately 42 percent lower (\$262 before age one, \$449 between ages two and three) over a 5-year period than children who receive their first preventive between the ages of two and three.⁹ Regrettably, however, less than 20 percent of Medicaid-eligible children received dental treatment services in 2010.¹⁰ Institutionalized seniors face even greater challenges in accessing oral health services.

Nearly 80 percent of the nursing home population has untreated dental caries.¹¹ Preventive care can diminish the need for more costly restorative and emergency care, saving valuable health care dollars in the long-run.

DENTAL HYGIENISTS ARE PRIMARY PROVIDERS AND IMPACT ACCESS TO CARE

Dental hygienists are prevention specialists who understand how the connection between oral health and total health can prevent disease, treat problems while they are still manageable, conserve critical healthcare dollars, and save lives. Dental hygienists are primary care oral health professionals who provide a range of oral health services including prophylaxis (cleaning), sealants, fluoride treatments, oral cancer screenings and oral health education.¹²

In order to become licensed as a dental hygienist, an individual must graduate from one of the Nation's 332 accredited dental hygiene education programs and successfully complete both a national written examination and State or regional clinical examination. The average entry-level dental hygiene education program is 86 credits, or about 3 academic years, in duration.¹³ Over 6,700 dental hygienists graduate annually from entry level programs that offer a certificate, or an Associate's or Bachelor's degree.¹⁴ There are currently more than 20 Master's-degree dental hygiene education programs in 16 States. In 48 States and the District of Columbia, dental hygienists are required to undertake continuing education as part of the licensure renewal process to maintain and demonstrate continued professional competence.¹⁵

As one of the fastest growing health care professions, as identified by the U.S. Bureau of Labor Statistics (BLS), the dental hygiene profession is well placed to significantly impact the delivery of care in the United States.¹⁶ BLS data indicates the number of dental hygienists is expected to grow 36 percent by 2018. In contrast, BLS data indicates that the profession of dentistry is experiencing only a 16 percent growth rate and anticipates the population of dentists "is not expected to keep pace with the increased demand for dental services."¹⁷ In States such as Vermont, North Carolina, Oregon, and Georgia, the number of licensed dental hygienists in the State far outweighs the population of licensed dentists.¹⁸ Furthermore, in Maine; the population of licensed dental hygienists nearly doubles that of licensed dentists.¹⁹

The dental hygiene profession with its continuing growth offers a cadre of competent and licensed providers who can deliver comprehensive primary care services in an increasing array of settings. Currently, 35 States have policies that allow dental hygienists to work in community-based settings (like public health clinics, schools, and nursing homes) to provide preventive oral health services without the presence or direct supervision of a dentist.²⁰ Among the 35 direct access States are the Senators' home States of Vermont, New Mexico, Pennsylvania, Oregon, Rhode Island, Iowa, Kentucky and Alaska. Direct access to dental hygiene services is especially critical for vulnerable populations like children, the elderly, and the geographically isolated who often struggle to overcome transportation, lack of insurance coverage, and other barriers to oral health care. In 1998, California and Washington became the first States to recognize and reimburse hygienists as Medicaid providers. Today, 15 States (Arizona, California, Colorado, Connecticut, Maine, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, Oregon, Washington and Wisconsin) recognize and reimburse hygienists as Medicaid providers.²¹ Medicaid dental regulations must be updated to better reflect the way State dental practice acts have evolved and the way dental care is now delivered.

Dental hygienists throughout the country have demonstrated their ability to reach patients in alternative settings, thus drawing those who are currently disenfranchised from the oral health care system into the pipeline for care. In South Carolina, a school-based program brings dental hygienists directly to low-income students in 341 schools in 38 targeted school districts. Importantly, the program has 12 restorative partners, dentists who agree to see referred children in their private offices, thus promoting the receipt of comprehensive services. Data from the State has demonstrated that in the 5 years since the program effectively began, sealant use for Medicaid children increased while the incidence of untreated cavities and treatment urgency rates decreased for that population.²² Indeed, the 2007-8 Needs Assessment showed that there are presently no disparities between black and white third grade children for sealant use in South Carolina.²³

A program in Michigan, Smiles on Wheels, run by three dental hygienists, brings care directly to patients living in nursing homes who are not able to travel for dental care. For more than a decade, California has recognized "Registered Dental Hygienists in Alternative Practice" (RDHAPs) who provide unsupervised services in homes, schools, residential facilities and in Dental Health Professional Shortage

Areas. A recent study of RDHAPs in California found that “alternative care delivery models such as RDHAP are essential to improving oral health and reducing health disparities.”²⁴

Direct access and direct reimbursement policy changes better leverage the existing dental hygiene workforce and make care more accessible for those who currently struggle to secure services in the private dental office. Bringing patients into the oral healthcare system for preventive and other oral healthcare services through additional access points such as schools, community health centers, and nursing homes can avert more costly restorative care, allow appropriate referral to dentists, and help save valuable healthcare dollars in the long-run.

NEW ORAL HEALTHCARE PROVIDERS DEVELOPED TO IMPROVE ACCESS TO DENTAL CARE

The significant challenges millions of Americans face in accessing restorative dental care are well-documented. In response to the access crisis, State policymakers, consumer advocates and oral health coalitions are pioneering innovations to extend the reach of the oral health care delivery system and improve oral health infrastructure. Among these innovations is the creation of a mid-level oral health provider to provide much-needed restorative dental care to underserved populations. Currently, more than 50 countries, including Canada, New Zealand, Australia, and the United Kingdom, allow mid-level practitioners to practice in oral health.²⁵ In Alaska, Dental Health Aid Therapists (DHATs) have provided restorative oral health care services without a dentist onsite since 2004.²⁶ In an evaluation issued by the W.K. Kellogg Foundation, researchers found that non-dentist providers safely and efficiently deliver quality oral health care to patients and improve access to services.²⁷

In recognition of increasing patient need and workforce realities, ADHA, the American Dental Association and others have called for new types of oral health care providers. ADHA welcomes a robust review of all new provider models. In 2004, ADHA became the first national oral health organization to propose a new oral health provider, the Advanced Dental Hygiene Practitioner (ADHP) and the ADHP competencies were created.²⁸ The ADHP is designed to be a primary care dental professional able to deliver care in a capacity between that of a dentist and a dental hygienist. The ADHP model was developed after review of advanced nursing models in the United States and “mid-level” oral health models internationally. The ADHP would provide preventive, therapeutic, diagnostic, prescriptive, and minimally invasive restorative services directly to the underserved. The ADHP would be a member of a comprehensive healthcare team, and would refer patients in need of more advanced oral healthcare services to dentists. An ADHP would be State-licensed and a graduate of an accredited educational institution.

In 2009, Minnesota became the first State to pass legislation creating two new types of oral health practitioners, a dental therapist and an advanced dental therapist, making new providers a reality in the lower 48 States.²⁹ Metropolitan State University in St. Paul, Minnesota offers a Master’s level program that educates students, using the ADHP competencies, to practice as Advanced Dental Therapists (ADTs) in Minnesota. This program builds on the dental hygiene education model by requiring students to have dental hygiene licensure and a Baccalaureate degree prior to entry. The ADT is modeled after the nurse practitioner model and is designed to facilitate collaboration between the ADT and dentist, but does not require onsite supervision. The first class of ADT students graduated from Metropolitan State in June 2011 and will need 2,000 hours of supervised practice before they can obtain their ADT certification. They will then practice with dual ADT and dental hygiene licensure. By virtue of their dual licensure, ADTs are able to provide the full preventive skill set of a dental hygienist in addition to the ADT restorative skill set.

The dental therapist program offered at the University of Minnesota is modeled after the physician’s assistant model which requires onsite supervision from a dentist for most services provided. This program does not require entering students to first be a licensed dental hygienist.

In addition to Alaska and Minnesota, the W.K. Kellogg Foundation announced it was spearheading a \$16 million campaign to establish mid-level practitioner models in Kansas, New Mexico, Ohio, Vermont, and Washington State.³⁰ The trend is toward combining the dental therapist model with a dental hygiene-based model that builds on the education and expertise of the existing dental hygiene workforce. This is a particularly sensible approach when future U.S. oral health workforce projections are taken into account.

ADHA is a proponent of exploring new workforce models in dentistry and exploring better ways of utilizing existing dental and medical providers. ADHA believes patients will benefit most from mid-level providers who are rooted in dental hy-

giene, as these providers can deliver both preventive and minimally invasive restorative care. As such, ADHA supports dental hygiene-based workforce models that are licensed, receive appropriate education for their respective scope of practice from an accredited institution and can provide care directly to the public.³¹

ALTERNATIVE DENTAL HEALTH CARE PROVIDERS DEMONSTRATION PROJECTS

Congress recognized the need to improve the oral health care delivery system when it authorized the Alternative Dental Health Care Provider Demonstration Grants, Section 340G-1 of the Public Health Service Act. The Alternative Dental Health Care Providers Demonstration Grants program is a Federal grant program that recognizes the need for innovations to be made in oral health care delivery to bring quality care to the underserved by pilot testing new models. This is an opportunity for dental education programs, health centers, public-private partnerships and other eligible entities to apply for funding that will allow for innovation, *within the confines of State laws*, to further develop the dental workforce and extend the reach of the oral health care system. This grant program, administered by the Health Resources and Services Administration (HRSA), would fund workforce innovations, including building on the existing dental hygiene workforce, utilizing medical providers, and pilot testing new providers, like dental therapists and advanced practice dental hygienists, who practice in accordance with State practice acts.

Dental workforce expansion is one of many areas that need to be addressed as we move forward with efforts to increase access to oral health care services to those who are currently not able to obtain the care needed to maintain a healthy mouth and body. The authorizing statute makes clear that pilots must “increase access to dental care services in rural and underserved communities” and comply with State licensing requirements. Such new providers are already authorized in Minnesota and are under consideration in Vermont, Kansas, Maine, New Hampshire, Washington State and several other States.

The fiscal year 2012 Labor, Health and Human Services funding bill included language designed to block funding for this important demonstration program. We seek your leadership in removing this unjustified prohibition on funding for the Alternative Dental Health Care Providers Demonstration Grants. The Federal Government must signal that investment in exploring new ways of delivering dental care is a meritorious expenditure, and underscores the Nation’s commitment to expanding access to critical oral healthcare.

Please keep the following points in mind as you consider funding this dental workforce grant program for the underserved:

- The existing dental delivery model has increased in efficiency and is highly effective for those who have access to a dental office and are covered through insurance. However, the system fails the more than 80 million Americans who lack dental insurance, those who are geographically isolated, and those who are unable to travel to a private dental office for treatment.
- Reports that these workforce pilots will allow non-dentists to do dental surgery/irreversible procedures are unfounded. All grants must, by statute, be conducted in accordance with State law. The grant program cannot authorize or allow non-dentists to perform irreversible/surgical dental procedures UNLESS State law allows for the provision of such services.
- All pilots must be specifically designed to increase access in rural and other underserved areas. This is a dental workforce grant program for the underserved.
- Nearly 48 million Americans live in dental health professional shortage areas according to the Health Resources and Services Administration (HRSA), and HRSA included funding for this program in its fiscal year 2012 budget justification.
- An estimated 9,500 new dental practitioners are needed to end the Nation’s dental care shortages. New types of models must be explored and, by statute, HRSA must contract with IOM to evaluate the demonstrations, which will yield valuable information to inform decisions about the dental workforce of the future.
- All evidence available demonstrates the safety and quality of care delivered by non-dentist providers, including for Dental Health Aide Therapists in Alaska. Dental therapists have successfully been in practice overseas for nearly a century. Funding to support pilot testing of new dental workforce models will yield additional data on the economic viability of new oral health providers.
- The Alternative Dental Health Care Providers Demonstration Program is a grant program to pilot dental workforce innovations that, by statute, must “increase access to dental health care services in rural and other underserved communities” and must be compliant with “all applicable State licensing requirements.” New types of dental providers are essential to solving the Nation’s oral health access crisis and this grant program will help determine what types of providers are viable.

The promise of the Alternative Dental Health Care Providers Demonstration program will go unfulfilled unless it is adequately funded. Without the appropriate supply, diversity and distribution of the oral health workforce, the current oral health access crisis will only be exacerbated.

ADHA, along with more than 60 other oral health care organizations, advocated for funding of these grants and for oral health workforce programs, as well as oral health prevention-related activities such as oral health literacy campaigns, dental caries and disease management grants, school-based sealant programs, and for the oral health infrastructure and national oral health surveillance efforts. ADHA is proud to support these efforts, which will improve the Nation's oral health, a fundamental part of overall health and general well-being.

CONCLUSION

The American Dental Hygienists' Association appreciates this subcommittee's interest in addressing the dental crisis in this country through expanding access to dental care in America. The oral healthcare delivery system needs significant restructuring to overcome barriers to care for the underserved. ADHA remains a committed partner in advocating for meaningful oral health programming that makes efficient use of the existing oral health workforce, explores new ways to provide dental care, improves access to care, and delivers high quality, cost-effective care. ADHA firmly believes that better utilization of the existing oral healthcare workforce will help improve access to care for vulnerable and underserved populations. Thank you for the opportunity to share ADHA's commitment to increasing access to comprehensive oral healthcare.

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PREPARED STATEMENT OF LILIA LARIN, D.D.S., MS, PRESIDENT,
HISPANIC DENTAL ASSOCIATION (HDA)

Chairman Sanders, Ranking Member Dr. Paul, and distinguished members of the Subcommittee on Primary Health and Aging, the members of the **Hispanic Dental Association (HDA)**, whose mission is to provide for the elimination of oral health disparities in the Hispanic community, welcomes today's hearing on a topic that is important not only to our Nation's oral health—but to the overall health of all Americans.

The Institute of Medicine's April 2011 report "Advancing Oral Health in America" affirms accessing oral health care is difficult for certain populations.

"While access has improved over time, many people—typically those who are most vulnerable—still lack the oral health services they need. Accessing oral health care is particularly difficult for certain populations, including people whose income falls below the Federal poverty level, African-Americans, Latinos, and children covered by Medicaid."¹

The Hispanic community continues to grow, composing 16 percent of the Nation's population according to the U.S. Census and accounting for more than half (51 percent) of the United States' population growth of 9 percent since 2000, according to the Pew Hispanic Center.

In November 2011, a nationally representative survey among 1,000 Hispanics and 1,000 general population adults, led by the HDA and sponsored by Procter & Gamble (P&G) brands Crest® and Oral-B®, found that Hispanics—the fastest growing segment of the U.S. population—have significant barriers to overcome to achieve better oral health.² Overall, Hispanics believe that more information about good oral health habits, better access to affordable oral health care, and more Hispanic and Spanish-speaking dentists and dental hygienists in their communities would help them "a lot" in achieving and maintaining good oral health.

The survey's results are quite revealing and alarming with respect to the lack of access to oral health care by the Hispanic population.

¹"Advancing Oral Health in America," Institute of Medicine of the National Academies Report Brief, April 2011.

²"Hispanics Open Up About Oral Health Care" survey conducted by GfK Roper Public Affairs & Corporate Communications, November 2011, www.hdassoc.org.

First and foremost, nearly one in five Hispanics, 18 percent, have not visited the dentist at all in the past 2 years, and only 30 percent of Hispanics are visiting the dentist regularly over the past 2 years (regularly as defined by two or more times a year). This is compared to 45 percent of the general population who stated that they visited the dentist regularly.

What is the main reason why so many Hispanics have missed a dental visit? The lack of dental insurance.

- **Approximately 16 million Hispanic adults do not have access to dental insurance.**

The lack of dental insurance among close to half of Hispanic adults, 45 percent, is one of the key reasons many Hispanics are not visiting the dentist regularly. In fact, 51 percent of Hispanics cite lack of insurance as a reason why they have ever missed a dental visit. *Hispanics are also far less likely to have access to dental insurance for their children, 56 percent.*

- **In sum, 7 in 10 Hispanics say it would help “a lot” if they had better access to adequate insurance or other dental coverage and better access to affordable oral health care.**

Moreover, even if individuals have dental insurance, other barriers may prevent or dissuade them from receiving much-needed services. Therefore, in addition to access to affordable care and insurance, oral health literacy (knowledge gaps) and cultural competence present significant barriers to many Hispanics. For example:

- **Forty-six percent of Hispanics do not know, or incorrectly believe to be false that poor oral health may be linked to other health complications, including stroke, heart disease and diabetes.**

- **Hispanics rely equally on their parents, 61 percent, and their dentist/hygienist, 60 percent, as sources for oral care information.**

- **Fifty-nine percent of Hispanics feel that more Hispanic dentists/hygienists in their community would be similarly helpful.**

We must work to correct the many misperceptions Hispanics have about oral health through education and awareness and work to address dental workforce shortfalls to increase the number of underrepresented minorities in health professions schools as well as promote cultural and linguistic competence in the health professions. In fact, the Council on Graduate Medical Education (COGME), a committee authorized by Congress in 1986, has issued reports calling for the need to increase underrepresented minorities in health professions.³

The existence of all these barriers makes preventative measures such as community water fluoridation become all the more important, especially to underserved or vulnerable populations. Preventative measures provide an easier, less costly solution to treatment.

In conclusion, the Hispanic Dental Association is committed to working with all oral health stakeholders and policymakers to improve the State of oral health among the growing U.S. Hispanic population and for all Americans.

Thank you.

[Whereupon, at 11:26 a.m., the hearing was adjourned.]

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³<http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/index.html>.