ADA American Dental Association®

STATEMENT OF THE

AMERICAN DENTAL ASSOCIATION

TO THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON ENERGY AND COMMERCE

U.S. HOUSE OF REPRESENTATIVES

ON

"EXAMINING INITIATIVES TO ADVANCE PUBLIC HEALTH"

BY

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Executive Summary

My name is Dr. Cheryl Watson-Lowry. I'm a general dentist with an inner-city practice in Chicago, Illinois. The "Action for Dental Health Act of 2017" has the potential to positively affect every patient in my practice, which is why I am so passionate about it.

The ADH bill supports grant programs that help: volunteer dental projects that provide free care directly to those in need; and Action for Dental Health (ADH) initiatives designed to address the many barriers to accessing oral health care services.

Regarding volunteer projects, each year, approximately 450,000 children benefit from 1,500 Give Kids A Smile (GKAS) events nationwide. Also, since 2003, the program has provided free oral health care services to over 5.5 million children. Since 2003, Missions of Mercy events have helped more than 243,000 patients and provided $159 million in free oral health care.

There are eight ADH initiatives but this testimony focuses on the need to grow the number of emergency room (ER) referral programs and to support the community dental health coordinator (CDHC) program.

ER referral programs result in clear savings to the health care delivery system and, in particular, to government-funded programs, as the Medicare or Medicaid programs were the primary payer for almost half of ER dental visits in 2012 (43.2%). The bottom line is that in most cases an individual can receive an entire year's worth of dental services for the price of a single visit to the ER for a dental emergency.

The use of CDHCs can connect patients to dental homes, ensuring that timely care is delivered in the most appropriate, cost-effective venue possible.

The role of a CDHC is threefold: educating the community about the importance of dental health and healthy behaviors; providing limited preventive services, such as fluoride varnish and dental sealants; and connecting the community to oral health teams that can provide more complex care. CDHCs work in inner cities, remote rural areas and Native American lands. Most grew up in these communities, allowing them, through cultural competence, to better understand the problems that limit access to dental care.

A September 2013 evaluation of 88 case studies of the CDHC program conducted by the ADA verified the real world value of the CDHC in making the dental team more efficient and effective. Screenings, dental education and certain preventive services were delivered by the CDHC and individuals needing additional care did not “fall through the cracks” of a complicated delivery system. Before the end of this summer, the CDHC program will have over 100 graduates working in 21 states. This includes 16 CDHCs working in tribal facilities.

Testimony

On behalf of the American Dental Association (ADA) and our 161,000 members, thank you, Mr. Chairman, for the opportunity to testify today in support of the "Action for Dental Health Act of 2017", introduced by Rep. Robin Kelly of Illinois.

My name is Dr. Cheryl Watson-Lowry. I'm a practicing general dentist from Chicago, Illinois, and a member of the ADA. My practice is in the inner city and I see patients from 1 to 107 years of age. My patients range from professionals, politicians, teachers, and police officers to students and fast food workers. I even have one patient that sells incense on the train to pay his bills -- including paying for his dental services. Action for Dental Health (ADH) initiatives affect or have the potential to positively affect every patient in my practice, which is why I am so passionate about it.

The bill will allow organizations to qualify for oral health grants to support activities that improve oral health education and dental disease prevention and develop and expand outreach programs that facilitate establishing dental homes for children and adults, including the elderly, blind and disabled.

The ADH bill supports oral health initiatives that have the greatest impact on dental access disparities, including:

Volunteer Dental Projects

Programs like Give Kids A Smile and Missions of Mercy provide important platforms for dentists to deliver free dental care directly to those in need.

- Each year, approximately 450,000 children benefit from 1,500 Give Kids A Smile (GKAS) events nationwide. Since 2003, the program has provided free oral health care services to over 5.5 million children. [1]These are generally not single day events as the mantra for GKAS is "more than just a day," which points to the need to get these individuals into dental homes.

- Since 2003, Missions of Mercy events have helped more than 243,000 patients and provided $159 million in free oral health care.[2]

- These programs, along with the free and discounted care that individual dentists provide every day, add up to an estimated $2.6 billion per year.[3]

Action for Dental Health Initiatives

Healthy teeth and gums aren't a luxury. They're essential.

That's why the ADA in 2013 launched Action for Dental Health: Dentists Making a Difference, a nationwide, community-based movement aimed at ending the dental health crisis facing America today.

All Americans deserve good oral health.

The causes of dental disease are varied and complex, but we know that for each of us – and for the nation as a whole – it's never too late to get on top of our dental health. Action for Dental

[1] http://www.adafoundation.org/en/give-kids-a-smile.
[2] http://www.adcfmom.org/.
[3] http://www.ada.org/en/public-programs/action-for-dental-health/provide-care-now.

Health (ADH) aims to prevent dental disease before it starts and reduce the proportion of adults and children with untreated dental disease. Our goal is to help all Americans attain their best oral health.

ADH initiatives are designed to deliver care *now* to people already suffering from dental disease, strengthen and expand the public/private safety net, and amplify dental health education and disease prevention into underserved communities.

The ADH program is composed of eight initiatives[4] designed to address specific barriers to care.

Emergency Room Referral: Many people without dental coverage do not seek treatment until their dental pain grows so severe that it sends them to a hospital emergency room. But most hospitals cannot provide comprehensive dental care, so the problem often is not solved. Dentists and oral health clinics around the country are working with hospitals to get these patients out of the ER and into the dental chair, the right place for the right treatment.

Community Dental Health Coordinators: Community Dental Health Coordinators (CDHCs) address barriers to oral health by providing patient navigation for people who typically do not receive care for a variety of reasons—among them poverty, geography, language, culture, and a lack of understanding of oral hygiene and the importance of regular dental visits. CDHCs typically work in inner cities, remote rural areas and Native American lands connecting patients in need to available but underutilized dental access points through case management and care coordination.

Fluoridation: Studies prove community water fluoridation continues to be effective in reducing dental decay by at least 25 percent in children and adults. Even with the availability of secondary

[4] http://www.ada.org/en/public-programs/action-for-dental-health/action-for-dental-health-initiatives.

sources of fluoride through toothpaste and varnishes, community water fluoridation remains one of the top 10 public health achievements of the 20th century.

Medicaid Reform: Most state Medicaid dental programs fall short of providing the amount and extent of care—both preventive and restorative—needed by their low-income beneficiaries. This is especially true for low-income adults, many of whom have virtually no access to dental care through Medicaid. The ADA advocates for increased dental health protections under Medicaid, especially in states that have yet to agree to a Medicaid expansion, and helps more dentists work with community health centers and clinics. The ADA works with states to reduce the administrative burdens often associated with being a Medicaid provider.

Federally Qualified Health Centers: When private-practice dentists contract with Federally Qualified Health Centers, they are able to help these safety net facilities expand their capacity to provide care to underserved populations – primarily children on Medicaid – without increasing the clinics' "bricks and mortar" expenses and staffing overhead. Patients benefit because quality care can be quickly and efficiently delivered, alleviating much of the backlog experienced by many health center dental programs. It truly becomes a community effort with both the public and private sectors contributing to this success.

Nursing Home Programs: America's vulnerable elderly face the greatest barriers to accessing dental care of any population group. But delivering dental care to the nearly 1.3 million seniors in long-term care facilities remains problematic. Now, dentists and dental training programs across the country are adopting nursing homes in their communities with the cost of care offset by a provision in Medicaid currently used to supply eyewear and hearing aids to needy patients.

Collaborations with other Health Professionals and Organizations: Better collaboration among dental and medical professionals can help more families understand that their dental health is a crucial part of their overall health. The dental health of a pregnant woman or a mother can affect the health of the baby. Diabetes and gum disease are interrelated. Physicians, nurses, and other medical providers can dramatically increase the number of patients and caregivers who receive basic dental health education through the ADA-endorsed online oral health curriculum entitled: Smiles for Life. These professionals also can be trained to recognize conditions needing diagnosis and possible treatment by a dentist. To date, over one million professionals have accessed this online educational series.

Missions of Mercy/Give Kids A Smile: Missions of Mercy events are temporary dental field hospitals that provide free dental care to the underserved. Give Kids A Smile programs allow dentists across the country to join with others in their communities to provide care to underserved children. An overarching goal of the programs is to provide each child with a dental home. At the events, dentists and other team members volunteer their time and services to provide screenings, treatments and education to children.

In fact, there are ADH initiatives in virtually every state as detailed in the state-by-state action maps found at the following site: http://www.ada.org/en/public-programs/action-for-dental-health/action-for-dental-health-map.

For the purposes of this hearing, however, I would like to focus on just two of the ADH initiatives potentially most affected by the ADH bill -- emergency room/emergency department referrals and community dental health coordinators.

Emergency Room/Emergency Department Referral Programs

A key initiative in the ADH program is reducing the number of people who visit the emergency room for a dental condition by referring them to dental practices, where they can receive proper dental care.[5]

- Emergency department (ED) visits for dental problems cost nearly $3 billion during the period from 2008 through 2010, according to a study in the *Journal of the American Dental Association* (April 2014, Vol. 145:4, pp. 331-337).

- The study noted that providing dental care in the ED costs more than providing regular care by oral health professionals. Also, most ED visits only provide patients with pain medication and antibiotics, while not treating the underlying problem.

Many people without dental coverage postpone seeking treatment until their dental pain grows so severe that it sends them to a hospital emergency room. Many patients are unaware of dental access locations and visit emergency rooms almost as a reflex action. But most hospitals cannot treat the underlying cause of the oral health emergency, so the problem often is not solved. Dentists around the country are working with hospitals to get these patients out of the ER and into the dental chair, the right place for the right treatment.

[5] According to the National Hospital Ambulatory Medical Care Survey, the number of dental ER visits in the U.S. increased from 1.1 million in 2000 to 2.1 million in 2010. A separate study shows that in 2009, dental caries (the disease that causes cavities) and abscesses alone – almost entirely preventable conditions – accounted for nearly 80 percent of dental-related ER visits.

ER referral programs result in clear savings to the health care delivery system and, in particular, to government-funded programs, as the Medicare or Medicaid programs were the primary payer for almost half of ER dental visits in 2012 (43.2%).[6] In 2012, an ER visit for a dental condition happened every 15 seconds in the United States, costing taxpayers $1.6 billion. That came out to about $749 per visit.[7] Adults with private dental benefits, ages 18-64, spent in a year (2015 dollars) on average between $323 and $523. If we look at the same age range (19-64) and same utilization of services, the range in average spending per year for people that pay strictly out of pocket (i.e. cash patients, or perhaps uninsured patients) is $492 to $785.[8] The bottom line is that in most cases an individual can receive an entire year's worth of dental services for the price of a single visit to the ER for a dental emergency.

Currently, there are hundreds of ED referral programs in virtually every state in the United States.[9] There are a variety of referral models,[10] as many of these programs are the result of local interest in addressing an obvious need to reduce costs and provide comprehensive dental care. At least in part as a testament of how successful these programs have been is that more recent research indicates that the use of emergency rooms for dental conditions is decreasing.[11] Some programs are reporting that use of the ED for dental pain patients has decreased 50-70 percent.

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[6] Wall T, Vujicic M. Emergency department use for dental conditions continues to increase. Health Policy Institute Research Brief. American Dental Association. April 2015. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0415_2.ashx

[7] Wall T, Vujicic M. Emergency department use for dental conditions continues to increase. Health Policy Institute Research Brief. American Dental Association. April 2015. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0415_2.ashx.

[8] Yarbrough C, Vujicic M, Aravamudhan K, Blatz A. An analysis of dental spending among adults with private dental benefits. Health Policy Institute Research Brief. American Dental Association. May 2016. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0516_1.pdf

[9] http://www.ada.org/en/public-programs/action-for-dental-health/action-for-dental-health-map.

[10] 2017 ER Referral Program Models and Description, Action for Dental Health, ADA.

[11] Wall T, Vujicic M. Emergency department visits for dental conditions fell in 2013. Health Policy Institute Research Brief. American Dental Association. February 2016. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0216_1.ashx.

The ADA believes that the use of community dental health coordinators (CDHCs) can continue this trend, connecting patients to dental homes and ensuring that timely care is delivered in the most appropriate, cost-effective venue possible.

Community Dental Health Coordinators

The ADA's commitment to improving America's oral health has led us to invest more than $7 million in the CDHC program. This program trains individuals to directly address the underlying social determinants of health by providing patient navigation, oral health information, and preventive self-care for people who typically do not receive dental services for a variety of complex reasons --- poverty, geography, language, culture, diet, and a lack of understanding of why it is important to achieve and maintain a healthy mouth.

The role of a CDHC is threefold: educating the community about the importance of dental health and healthy behaviors; providing limited preventive services, such as fluoride varnish and dental sealants; and connecting the community to oral health teams that can provide more complex care. CDHCs work in inner cities, remote rural areas and Native American lands. Most grew up in these communities, allowing them, through cultural competence, to better understand the problems that limit access to dental care.

A 2016 article by the ADA's Health Policy Institute[12] on the participation of dentists in the Medicaid program addresses the barriers preventing low-income individuals from accessing

[12] Is the number of Medicaid providers *really* that important? Health Policy Perspective (March 2016), http://jada.ada.org/article/S0002-8177(16)00023-4/pdf, p. 223.

dental services for reasons beyond just the participation of dentists. The article points out the need for more policy interventions that target patient behavior. CDHCs are specifically trained to address patient behavior and other barriers to accessing care.

The ADA and state dental societies are working with state governments, the higher education community, and the charitable and private sectors to create new CDHC programs. We believe that training CDHCs in greater numbers could dramatically improve oral health among people whose circumstances place them at greatest risk for untreated disease.

While all CDHCs have basic core competencies, their job responsibilities vary depending on the goals of the clinics and communities they serve, including:

- Increasing awareness of the importance of oral health and how to become and stay healthy, through community outreach.

- Improving health outcomes by bringing at-risk patients, such as people with diabetes and the elderly, to their clinics.

- Providing preventive services, such as fluoride treatments and sealants, with dentists and dental team members performing restorative and other more complex procedures as appropriate.

- Improving access to care by providing assistance with establishing dental homes for people in the community and significantly reducing missed appointment rates at

community health centers.

The CDHC model has been adapted to both private practice and numerous community dental settings, including clinics, schools, Head Start centers, institutional settings, churches, social service agencies and others.

A September 2013 evaluation of 88 case studies of the CDHC program conducted by the ADA verified:

- There are increases in necessary services rendered at clinics that add a CDHC to the dental team. One clinic experienced over a 100% increase in necessary procedures (from 1,066 to 2,307) in one year with the total value of care provided increasing from $91,399 to $231,551.

- Many children receive dental screenings and preventive services through elementary school, high school, juvenile detention center, and Head Start outreach programs. Over 5,200 patients were treated through these programs with hundreds of thousands of additional needed procedures provided by dentists or others on the dental team.

- Increased services were provided to patients with diabetes and HIV patients in community health centers. These three programs experienced fewer missed appointments, provided care to hundreds of patients, and provided over $100,000 in necessary services.

- Dental screenings and preventive services are provided to senior citizens and to the very young through pediatric outreach programs, among other programs. Almost 1,600 patients were seen in these programs with results similar to those cited above.

The bottom line is that the data collected as part of the evaluation demonstrated the real world value of the CDHC in making the dental team more efficient and effective. Screenings, dental education and certain preventive services were delivered by the CDHC and individuals needing additional care did not "fall through the cracks" of a complicated delivery system.

Community Dental Health Coordinators – In Their Own Words

"It's rewarding at the end of each day to know I guided someone and provided hope. Guiding someone to access to care is the first thing people need to start their journey to better health."
— **Angela Black,** 2011 CDHC graduate, University of Oklahoma-College of Dentistry

"I think the CDHC has the potential to make a real impact on so many patients' lives as a critical addition to the dental care team."
— **Calvin Hoops** (right), 2011 CDHC graduate, Temple University

"I am working to improve my people's oral health."
— **Teresa Molina**, 2012 CDHC graduate, Arizona School of Dentistry and Oral Hygiene

Before the end of this summer, the CDHC program will have over 100 graduates working in 21 states. This includes 16 CDHCs working in tribal facilities, including clinics serving the Chickasaw Nation Division of Health, Wewaka Indian Health, and the Muskogee Creek Nation in the Oklahoma City area. And more are being trained. For example, five Navajo trainees are currently part of the class at Central Community College in New Mexico. Presently, the Chickasaw Nation is working on a grant to begin a program with Pontotoc Technical College.

Mr. Chairman, thank you for this opportunity to share with you and the subcommittee why the ADA believes the Action for Dental Health Act of 2017 is an important piece of legislation that will enhance ongoing efforts to reduce the barriers to oral health care facing many Americans today.

The ADA looks forward to working with Representative Kelly and the committee in moving this bill through the legislative process.