COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS

SUBCOMMITTEE ON PRIMARY HEALTH AND AGING

American Academy of Pediatric Dentistry

Statement for the Record

Dental Crisis in America:

The Need to Expand Access

Wednesday, February 29, 2012

Dirksen Senate Office Building

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 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 recent 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 time frame**. Nearly 60% 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 2007–2010 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 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 three 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 three-year oral health literacy campaign. The Ad Council, known for such iconic public service advertising campaigns as Smokey Bear's "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 three-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 website.[5]

AAPD members have contributed to the development of state-wide 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 Carolina[7] and the Michigan Healthy Kids Dental[8] 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 below, 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 program 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 four 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 the 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 to5, $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 thirteen 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, Wash., 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 website.[29]

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[1] American Dental Association, Survey Center, *Surveys of Dental Practice, 2011.*

[2] This article was part of an entire issue of the journal *Academic Medicine* (November 2008, Volume 83, Issue 11) devoted to Title VII issues.

[3] The two-to three-year pediatric dentistry residency program, taken after graduation from dental school, immerses the dentist in scientific study enhanced with clinical experience. This training is the dental counterpart to general pediatrics. The trainee learns advanced diagnostic and surgical procedures, along with:

> • child psychology and behavior guidance • oral pathology • pharmacology related to the child • radiology • child development • management of oral-facial trauma • caring for patients with special health care needs • sedation and general anesthesia.

Three-year programs generally require additional master's-level research and often prepare trainees for careers in academic dentistry.

[4] The term "dental home" refers to an ongoing relationship between a dentist and patient, inclusive of all aspects of oral health care delivery in a comprehensive, continuously accessible, coordinated and family-centered way. The AAPD and other professional organizations involved in children's oral health recommend that a dental home be established by no later than 12 months of age and include referrals to dental specialists when appropriate.

[5] http://www.aapd.org/parents/

[6] http://abcd-dental.org/

[7] http://www.ncdhhs.gov/dph/oralhealth/partners/IMB.htm

[88] http://www.deltadentalmi.com/Individuals/Healthy-Kids-Dental-and-MIChild/Healthy-Kids-Dental.aspx

[9] http://pointsoflightonline.org/

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[19] American Dental Association, Survey Center, *Surveys of Dental Practice, 2011*

[20] American Dental Association, Survey Center, *Surveys of Dental Practice, 2011*

[21] Testimony of Christy Jo Fogarty, RDH, MSOHP before the U.S. Senate Subcommittee on Health, Education, Labor, and Pensions Subcommittee on Primary Health and Aging Hearing on Dental Crisis in America: the need to expand access February 29th, 2012.

[22] http://abcd-dental.org/ Accessed February 28, 2012.

[23] General Accounting Office (GAO). Oral health: Dental disease is a chronic problem among low-income populations; U.S. General Accounting Office, Report to Congressional Requeters. HEHS-00-72, April 2000.

[24] General Accounting office. Oral health: factors contributing to low use of dental services by low-income populations; U.S> General accounting Office, Report to Congressional Requesters. HEHS-00-149, September, 2000.

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[29] http://www.aapd.org