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Statement before the U.S. Senate Committee on Health, Education, Labor and Pensions, Subcommittee on Primary Health and Aging

February 29, 2012

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.

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 2009-2010 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 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 one 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 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.

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[1] U.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 one to 19. Data from the 48 reporting states and the District of Columbia were supplemented with reports obtained directly from Michigan and Oregon.

[2] U.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).

[3] U.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.

[4] S.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.

[5] N. 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).

[7] Agency 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 four-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.

[8] Of 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), Vol. 10, 212-222, http://www.jebdp.com/article/S1532-3382(10)00183-1/abstract.

[9] P. 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): 650-657.

[10] California HealthCare Foundation, "Emergency Department Visits forPreventable 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 Service, *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.

[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).

[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, "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).).

[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): 807-815.
[33] Institute of Medicine. *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*, 15 (July 2011).