

**Committee on Health, Education, Labor and Pensions  
Subcommittee on Primary Health and Aging  
United States Senate**

**“Dental Crisis in America: The Need to Expand Access”**

**A Statement for the Record  
submitted by the  
American Dental Association**

**February 29, 2012**

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.<sup>1</sup>

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 thirty 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% in 2000 to 57.3% 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%.<sup>2</sup> 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.<sup>3</sup>

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

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<sup>1</sup> The 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.

<sup>2</sup> *The State of Children’s Dental Health: Making Coverage Matter*, Pew Center on the States, May 2011, p.21-22.

<sup>3</sup> *Ibid*, p.23.

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 dental 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 five-year strategic action plan, focusing on education and training, advocacy, research, dental practice and coalition-building. One of the Association's three-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 on site 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 off-site 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 twenty 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 populations 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 two 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 three 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 three 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 two 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 on-site 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 Midlevel 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 midlevel program, you've seen one foreign midlevel 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 midlevels to deliver surgical procedures to children) have poorer oral health index scores than we have here in the United States.

Dental midlevel 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 six years of post high school education, not the two years or less suggested for many dental therapist models. Surgical procedures are not part of the scope of practice of medical midlevels, in stark contrast to the proposed dental midlevel providers.

Significant differences also are present among various dental midlevel 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 midlevel 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 US 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 WK 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 benefitted 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 two-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 midlevels in 40 countries as evidence that a midlevel 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 midlevel 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 midlevel 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 midlevels' 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 midlevel'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 midlevel's training. If your only tool is a hammer, every problem looks like a nail.
- A greater and broader weakness among proponents of midlevel practitioners is their near-obsessive focus on midlevels 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 naïve 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 midlevels. 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.