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October 17, 2017

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Strategic Planning Team
Attn: Strategic Plan Comments
200 Independence Avenue S.W.
Room 415F
Washington D.C. 20201

RE: Comments on the Draft Strategic Plan FY 2018-2022

Pursuant to a Request for Comments on the Draft Department Strategic Plan for FY 2018-2022, 82 Fed. Reg. 45032 (September 27, 2017), the American Dental Association (ADA), on behalf of our 161,000 members, is pleased to offer recommendations concerning issues addressed in the draft affecting the oral health of the American public and to also offer some additional oral health initiatives the department may consider adopting as part of its strategic plan.

Oral Health Issues Addressed in Draft

Concerning strategic goal 1: Reform, Strengthen, and Modernize the Nation's Health Care System

Issue: Under "Promote higher value and lower cost healthcare options" on page 8, lines 182-183, it states:

> *Promote the use of high-quality, lower cost healthcare providers, such as community health workers, dental therapists, and community organizations, where appropriate.*

Comment: The ADA recommends that the department include in its strategic plan Community Dental Health Coordinators (CDHCs), who are community health workers with dental skills, among the providers who represent a high-quality, lower cost healthcare option. The ADA's commitment to improving America's oral health has led us to invest more than $7 million in the CDHC program. This program trains individuals to directly address the underlying social determinants of health by providing patient navigation, oral health information, and preventive self-care for people who typically do not receive dental services for a variety of complex reasons --- poverty, geography, language, culture, diet, and a lack of understanding of why it is important to achieve and maintain a healthy mouth.

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

A 2016 article by the ADA's Health Policy Institute[1] on the participation of dentists in the Medicaid program addresses the barriers preventing low-income individuals from accessing dental services for reasons beyond just the participation of dentists. The article points out the need for more policy interventions that target patient behavior. CDHCs are specifically trained to address patient behavior and other barriers to accessing care. The ADA and state dental societies are working with state governments, the higher education community, and the charitable and private sectors to create new CDHC programs. We believe that training CDHCs in greater numbers could dramatically improve oral health among people whose circumstances place them at greatest risk for untreated disease.

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

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

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

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

- Improving access to care by providing assistance with establishing dental homes for people in the community and significantly reducing missed appointment rates within all dental delivery systems, be they public or private.

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

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

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

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

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

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

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

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

The ADA also requests that the department include in its strategic plan initiatives that reduce the number of people who visit the emergency room (ER) for a non-traumatic dental condition by referring them to dental practices or community health centers. Emergency room (ER) visits for non-traumatic dental problems cost more than providing regular care by oral health professionals. Also, most ER visits only provide patients with pain medication and antibiotics – but do not treat the underlying problem.

In 2010, 2.1 million Americans went to the ER for a dental problem. It is estimated that the U.S. spent nearly $3 billion on ER dental visits from 2008 through 2010, according to a study

in the *Journal of the American Dental Association* (April 2014, Vol. 145:4, pp. 331-337). ER referral programs result in clear savings to the health care delivery system and, in particular, to government-funded programs, as the Medicare or Medicaid programs were the primary payer for almost half of ER dental visits in 2012 (43.2%).[2] In 2012, an ER visit for a dental condition happened every 15 seconds in the United States, costing taxpayers $1.6 billion. That came out to about $749 per visit.[3] Adults with private dental benefits, ages 18-64, spent in a year (2015 dollars) on average between $323 and $523. If we look at the same age range (19-64) and same utilization of services, the range in average spending per year for people that pay strictly out of pocket (i.e. cash patients, or perhaps uninsured patients) is $492 to $785.[4] The bottom line is that in most cases an individual can receive an entire year's worth of dental services for the price of a single visit to the ER for a dental emergency.

Currently, there are hundreds of ER referral programs in virtually every state in the United States.[5] There are a variety of referral models,[6] as many of these programs are the result of local interest in addressing an obvious need to reduce costs and provide comprehensive dental care. At least in part as a testament of how successful these programs have been is that more recent research indicates that the use of emergency rooms for dental conditions is decreasing.[7] Some programs are reporting that use of the ER for dental pain patients has decreased 50-70 percent. The ADA believes that the use of community dental health coordinators (CDHCs) can continue this trend, connecting patients to dental homes and ensuring that timely care is delivered in the most appropriate, cost-effective venue possible.

CDHCs and ER referrals clearly offer a higher quality, lower cost alternative. *Please note, both the CDHC and the ER referral programs are part of a larger Action for Dental Health initiative described in greater detail below.*

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

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

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

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

[6] 2017 ER Referral Program Models and Description, Action for Dental Health, ADA.

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

Regarding the proposed promotion of dental therapists as a high-quality, lower cost health care provider, there is little empirical evidence (such as longitudinal clinical assessments of health outcomes) to support such a claim. The ADA knows 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. Concerning potential cost savings, existing dental therapist models in the United States are subsidized by sponsoring agencies and charge the same amount to payers as dentists. There are no savings for payers or patients and taxpayers are often shouldering an unnecessary burden. On the other hand, there are additional costs associated with setting up a new dental therapist program, requiring new curricula, a new accreditation process and a new system to test, license, and provide oversight. An assertion by proponents of dental therapists is that they will practice primarily in underserved and rural areas, but there is little evidence to substantiate that claim. In fact, seven years after the Minnesota program was created, there are 77 actively-licensed dental therapists in the state, only nine of which practice in a federally-designated rural area.[8]

Another common -- but incorrect -- assertion is that the dental workforce is aging and therefore declining in numbers, so there is a need for a new provider to help address the dental needs of a growing population. On the contrary, "the conventional wisdom that a looming retirement cliff will decrease the supply of dentists in the United States is not supported by the empirical evidence," according to Dr. Marko Vujicic, Chief Economist & Vice President of the ADA's Health Policy Institute (HPI).[9] In fact, the HPI model predicts the supply of practicing dentists will increase steadily through 2035, due largely to the growing volume of dental school graduates who will exceed the number of retirements from the profession.[10] Finally, it is important to understand that the current dental system has underutilized capacity, as nationally about 1 in 3 dentists say they are not busy enough,[11] so there is clearly no shortage of open chair time in many practices.

Issue: Under "Reduce disparities in access to health care" on page 16, lines 386 – 387, it states:

> *Support research to provide evidence on how to ensure access to affordable, physical, oral, vision, and behavioral, and mental health insurance coverage for children and adults.*

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[8] Minnesota Board of Dentistry, August 2017
[9] Vujicic, M. The "de-aging" of the dentist workforce. Health Policy Perspectives. JADA. 2016; 147(10): 843-845.
[10] Ibid.
[11] Vujicic, M. Solving dentistry's "busyness" problem. Health Policy Perspectives. JADA. 2015; 146(8): 641-643.

Comment: Ensuring access to affordable dental coverage for underserved children and adults is an extremely important component in reducing disparities in access to health care. The good news is that today more children have dental coverage than ever before in the United States. Between 2000 and 2012, the number of children without dental coverage decreased from 21.7 percent to 13.1 percent.[12] According to the ADA's Health Policy Institute, Medicaid expansion has improved access to dental care for low-income adults, allowing over 5 million adults to gain dental coverage. This has led to a decline in cost barriers to dental care for low-income adults and a modest increase in dental care utilization.

Expanded dependent coverage has also improved access to dental care for young adults. Although dental care was not subject to the expanded dependent coverage provision of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148; 111-152), dental insurance coverage for young adults expanded anyway through a "spillover" effect. This reduced financial barriers to dental care and increased dental care utilization for this age group.

Looking forward, the ADA believes it is vitally important, at a minimum, to retain the gains in coverage provided by the ACA. This requires the federal government to provide steadfast support for the ACA provisions offering subsidies to help low income individuals purchase coverage and for the expanded Medicaid program.

There is also a good deal that should be done at the federal level to provide states guidance on reducing administrative barriers to providing care to Medicaid beneficiaries. "Medicaid reform" is one of the ADA's Action for Dental Health initiatives listed below. More detail may be found at http://www.ada.org/en/advocacy/advocacy-issues/medicaid.

Issue: Under "Reduce disparities in access to health care" on page 16, lines 388 – 391, it states:

> *Identify individuals and populations at risk for limited health care access and assist them to access health services, including prevention, screening, linkages to care, clinical treatment, and relevant support services, including through mobilization of faith-based and community organizations.*

Comment: As stated in detail above, the ADA very strongly recommends the department include Community Dental Health Coordinators in its strategic plan as proven community health workers with needed dental skills who are specifically trained to identify individuals and communities at risk and to help those individuals and communities "connect the dots" within the cumbersome health care delivery system. CDHCs are the health care providers who can best help at risk individuals find the dental health care professionals they need in a

[12] Medical Expenditure Panel Survey, AHRQ.

timely fashion and offer cost-effective preventive and educational services that are delivered in a community-friendly manner.

In addition, the ADA compliments the department on its continued efforts to emphasize the importance of oral health during pregnancy. We recommend that these efforts be explicitly mentioned in this new strategic plan, such that all pregnant women receive instruction on oral hygiene care for themselves and their children, which emphasizes the importance of seeking timely and regular preventive dental services and includes information on how to access those services, especially for those women who qualify for government assistance programs.

Issue: Under "Reduce provider shortages in underserved and rural communities" on page 17, lines 416-419, it states:

> *Improve access to behavioral and oral health services in underserved and rural communities by supporting the training, recruitment, placement, and retention of behavioral health, dental health, and primary care providers to address workforce shortages, reduce disparities and ensure an equitable workforce distribution.*

Comment: The ADA has for many decades supported increased funding for the National Health Service Corps, the oral health division in the Indian Health Service, the oral health division of the Centers for Disease Control and Prevention, and Title VII General and Pediatric Residencies and the Dental Health Improvement Act within the Health Resources and Services Administration (HRSA). The Association has also long supported a variety of other HRSA programs that improve training, recruitment and/or placement of health care professionals in underserved and rural communities, such as the Health Careers Opportunity Program, Area Health Education Centers, and Maternal and Child Health – SPRANS.

For example, the ADA supported the omnibus spending package for fiscal year 2018 the House of Representatives passed on September 14 that includes $186 million ($3 million increase) for the Indian Health Service's oral health program, and $32.8 million ($2.5 million increase) for Area Health Education Centers (AHEC) that support programs to help patients find treatment outside of hospital emergency rooms. Report language accompanying the AHEC funding encourages the Health Resources and Services Administration to work with state dental associations with regard to patient referral programs, supporting a key initiative in the ADA's Action for Dental Health program.

Issue: Under "Collect, analyze, and apply data to better understand opportunities to strengthen the healthcare workforce" on page 18, lines 442-444, it states:

> *Examine state and tribal models that have allowed providers – such as midwives, nurse practitioners, and dental health therapists – to practice or provide care outside of a physician's or dentist's practice.*

Comment: In summary, as stated above:

- there are no studies 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;
- dental therapist programs in the United States have not proved sustainable without significant ongoing supplemental government or outside organizational spending;
- there are no cost savings to private or public sector payers or to patients (e.g. Medicaid reimbursement rates are the same for a given procedure regardless of who provides the service);
- there are additional training and potential licensing costs to the healthcare system;
- adding dental therapists to a state's provider mix does not necessarily result in more services for underserved and rural populations, as many therapists locate in urban areas; and
- there is no need for such a provider, as there are many more dentists coming into the profession and many current practitioners have open chair time.

There is, however, an access to oral health care problem for underserved and rural populations due to the *distribution* of dentists. Much more needs to done to provide incentives (e.g. National Health Service Corps (NHSC) loan repayments, tax credits for serving in underserved areas, etc.) and more needs to be done to improve the Medicaid program to enhance access. The economic and geographic barriers affect *all* providers who seek to provide care to underserved populations and in rural settings.

The dental therapist model is a "one size fits all" approach that misses the mark. Multiple barriers keep people from getting the dental care they need, including 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. Expanding the Action for Dental Initiatives (e.g. CDHCs, ER referrals, community water fluoridation) detailed below will make a real difference because it is multifaceted and places the emphasis on prevention.

Oral health and overall health are connected. Many patients who lack access to oral health care suffer from other health problems, such as diabetes, obesity, tobacco use, or excessive alcohol consumption that can complicate the provision of dental care. As doctors of oral health, dentists are uniquely qualified to identify these "comorbidities" and properly calibrate treatment plans. The ADA opposes allowing non-dentists (including dental therapists) to perform surgical dental procedures, such as "simple" extractions, restorations and pulpotomies as there can be unanticipated complications in any of these procedures, especially if the patient has one or more of the health problems cited above.

For all of these reasons, the ADA believes there is no need to promote a new provider who performs some, but not all, of the functions of a licensed dentist. The emphasis should be on directly addressing the many barriers to accessing dental care with a shift away from a model of "drilling, filling and extracting" to one of disease prevention. That is why the ADA started the Action for Dental Health program, as detailed below. The ADA requests that the department consider including some or all of these initiatives in its strategic plan.

Action for Dental Health
(Additional Oral Health Initiatives recommended for Strategic Plan)

All Americans deserve good oral health, as healthy teeth and gums aren't a luxury. They're essential. That's why the ADA in 2013 launched Action for Dental Health (ADH): Dentists Making a Difference, a nationwide, community-based movement aimed at ending the dental health crisis facing America today.

The causes of dental disease are varied and complex, but we know that for each of us – and for the nation as a whole – it's never too late to get on top of our dental health. ADH aims to prevent dental disease before it starts and reduce the proportion of adults and children with untreated dental disease. Our goal is to help all Americans attain their best oral health.

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

The ADH program is composed of eight initiatives[13] designed to address specific barriers to care.

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

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

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

connecting patients in need to available but underutilized dental access points through case management and care coordination.

Fluoridation: Studies prove community water fluoridation continues to be effective in reducing dental decay by at least 25 percent in children and adults. Even with the availability of secondary sources of fluoride through toothpaste and varnishes, community water fluoridation remains one of the top 10 public health achievements of the 20th century.

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

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

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

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

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

Please contact Ms. Janice Kupiec in the ADA's Washington. D.C. office at (202) 789 5177 or kupiecj@ada.org with any questions.

Sincerely,

Gary Roberts, D.D.S.
President

Kathleen T. O'Loughlin, D.M.D., M.P.H.
Executive Director

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