



November 4, 2011

Jerilyn K. Glass, M.D., Ph.D.
Acting Executive Secretary
Advisory Committee on Training in Primary Care Medicine and Dentistry
Health Resources and Services Administration
5600 Fishers Lane, Room 9A-27
Rockville, MD 20857

Dear Dr. Glass:

Thank you for the opportunity to comment on behalf of Community Catalyst on the Health Resources and Services Administration Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) draft *ACTPCMD Ninth Report: Priming the Pump of Primary Care*.

Community Catalyst, a national advocacy organization, has been giving consumers a voice in health care reform for more than a decade. We provide leadership and support to state and local consumer organizations, policymakers and foundations that are working to guarantee access to high-quality, affordable health care for everyone. Community Catalyst is working with the W. K. Kellogg Foundation to support the establishment of a new primary care dental provider in Kansas, New Mexico, Ohio, Vermont and Washington. The Pew Charitable Trusts is working on similar efforts in multiple states. Directing funds to allow HRSA to carry out its existing authority could jump-start innovation in the dental field and states debating the issue.

Community Catalyst supports the Committee's systemic approach to improving access to oral health care services. We share the belief that while no one solution will solve the access crisis, thoughtful consideration and testing of new models of delivering oral health care is a promising, and key area that must be explored in order to create new points of access into the dental delivery system. We also support efforts to better integrate the delivery of dental care with medical care to benefit consumers. It is time that dental professionals begin to think about new and innovative ways to increase access to care that are beyond the framework of the private practice dental office. As last year's GAO report detailed, delivering care to the underserved can be improved by adapting alternative dental workforce models. Community Catalyst applauds the ACTPCMD draft report for its thoughtful recommendations to offer systematic innovations that will improve access to, and the delivery of care.

We want to offer comments specifically on recommendation 11 to support the outcomes measures of the various expansions in dental workforce models currently being developed in the United States. It is critical that there is support to evaluate the emerging model's effect on health outcomes, fiscal efficiencies, and effective access within the national safety net for Medicaid recipients and the uninsured.

Why access to dental care is important for overall health

Oral health is essential to overall health. Yet, according to the American Dental Association over 83

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million Americans lack access to dental care. The inability to access dental care can have severe impacts not only on individuals but also on communities. Adults and children with dental problems are frequently absent from school, unable to focus in class and have decreased overall health, including potentially life threatening illnesses. Furthermore, the cost to taxpayers as a whole in both the short and long term increases due to children performing poorly in school, lost employee productivity due to pain and or time off, and increased demands on public health systems including emergency room visits (Pew Center on the States, "The Cost of Delay," 16-20, E. Davis, A. Deinard, and E. Maiga, "Doctor My Tooth Hurts: The Costs of Incomplete Dental Care in the Emergency Room," *Journal of Public Health Dentistry* (Spring 2010): 1-6). Improving access to dental care can have a tremendous positive impact not only on the success and health of the individual, but on the fiscal strain communities absorb as taxpayers.

In fact, a recent study by the Washington State Hospital Association found that dental complaints are the number one reason for non-insured adults to seek emergency room care. They are the sixth most common reason for Medicaid patients to seek emergency room care. According to the Washington State Hospital Association, dental emergencies often result from not having access to regular dental care (Washington State Hospital Association: Health Information Program, "Emergency Room Use," (2010)). The impact on individuals and taxpayers in Washington State was significant:

- Between January 2008 and June 2009, dental emergencies accounted for 23,459 emergency room visits in Washington, and \$12,474, 190 in expenditures.
- Between January 2008 and June 2009, some 9,538 ER visits by Medicaid patients experiencing dental emergencies cost nearly \$5 million.
- Dental emergencies costing more than \$3 million were the No. 1 reason that uninsured Washingtonians sought emergency room care between January 2008 and June 2009

With better access to regular dental care, we could cut those visits – and their attendant costs – substantially. As your report recommends – a more integrated approach to the delivery of care and the potential deployment of alternative providers could yield positive results.

A nationwide shortage of dentists is contributing to the inability to access dental care

In 2010, the ratio of dentists to population was at its lowest level in nearly 100 years, and 51 million Americans live in an area federally designated as having a shortage of dental professionals. Although the number of dental schools is expanding, many dentists are reaching retirement age, and the Bureau of Labor Statistics has stated that "employment of dentists is not expected to keep pace with the increased demand for dental services."

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Additionally, the small number of dentists willing to see low-income patients is creating a major barrier to care in state Medicaid programs. In 2008, fewer than half of the dentists in 25 states treated any Medicaid patients. That same year, only 11 million out of the 28 million Medicaid-enrolled children aged 1 to 18—roughly four in 10—received dental care. (Pew Center on the States, *Two Kinds of Dental Shortages Fuel One Access Problem*, (The Pew Charitable Trusts, 2011)).

There is potential for new workforce models to address access issues and provide quality care

Already, dental therapists have helped improve care for Alaska Natives. Since 2005, the Alaska Native Tribal Health Consortium (ANTHC) has employed dental health aide therapists (DHAT) to provide routine prevention and restorative oral health services in tribal health clinics in rural Alaska. Currently, there are 16 DHATs providing care to 19,942 people in communities that previously had no access to care. Minnesota recognized the potential for dental therapists and authorized their use in 2009. In a few months, dental therapists will be working in remote, underserved communities in Minnesota with the primary goal of treating underserved Medicaid patients.

The successful use of alternative providers in other countries is well documented. In the GAO report, a health official from New Zealand — where dental therapists provide dental services in school-based clinics — indicated that nearly all children aged 5 to 12 (96%) were enrolled in the nation’s publicly funded school-based dental program in 2009 (United States Government Accountability Office (GAO), “Oral Health: Efforts Under Way to Improve Children’s Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns,” (2010) GAO-11-96.). This is significantly higher than Medicaid utilization rate in the United States. In addition to increasing utilization of care in New Zealand, the decades long use of dental therapists has been shown to be effective at improving the oral health status of children, and reducing the rate of untreated dental decay (Nash et al.: *Dental Therapists: A Global Perspective*. *International Dental Journal* (2008) Vol. 58(2): 61-70).

Rigorous research internationally and domestically demonstrates that trained providers other than dentists can provide safe, quality dental care. In 2010, an evaluation of Dental Health Aide Therapists (DHATs) working in Alaska concluded that these practitioners were providing safe, high quality, effective and appropriate care to Alaskans who previously did not have access to care due to long waits and travel times. In a July 2011 report, the Institute of Medicine (IOM) found that there were no quality or safety concerns in regards to alternative dental providers.

Additionally, the IOM encouraged states to expand the roles of current dental providers and to develop new types of dental professionals. Finally, the IOM concluded that hygienists, dentists and other providers can have overlapping scopes of practice and increase access “without compromising quality, safety or patient satisfaction.”

Research by PEW Children’s Dental Campaign has shown that adding mid-level providers to the dental care team has not only the potential to increase access to dental care but can also improve the productivity and profitability of a dental practice. (Pew Center on the States, *It Takes a Team.*) Additionally, employing new midlevel providers, such as dental therapists or hygienists with dental therapy training,

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can make it financially viable for a private practice dentist to accept Medicaid patients as 20% of his practice. (The Pew Charitable Trusts, 2010).

While there is significant research supporting the efficacy of dental therapists in increasing access to care and delivering quality care, there is no evidence to contrary.

Furthermore, Australia and New Zealand have recently invested greater resources in expanding programs that deploy these providers. Dental therapists have proven to be successful in reaching underserved populations in Alaska and are already authorized in Minnesota. Alternative providers such as dental therapists are under consideration in California, Kansas, Maine, Missouri, New Hampshire, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, Washington and several other states because of their ability to increase access to care, and better deliver care to communities where there are not enough dentists to meeting the needs of the residents.

In conclusion, we fully support the committee's recommendations to develop an integrated approach to dental and medical care and the innovations in the delivery of care, including the evaluation of new dental workforce models.

We appreciate the opportunity to comment on this draft report. If you have any questions, please contact me, David Jordan, Director of the Dental Access Project, at 617-275-2817 or djordan@communitycatalyst.org.

Sincerely,

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