



STATEMENT OF THE

AMERICAN DENTAL ASSOCIATION

TO THE

SUBCOMMITTEE ON INTERIOR, ENVIRONMENT, AND RELATED
AGENCIES

COMMITTEE ON APPROPRIATIONS

U.S. HOUSE OF REPRESENTATIVES

ON

SUPPORT OF DENTAL AND ORAL HEALTH-RELATED INDIAN
HEALTH SERVICE PROGRAMS

SUBMITTED BY

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CHAIR, COUNCIL ON GOVERNMENT AFFAIRS

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Good afternoon Chairman Simpson, Ranking Member Moran and Committee Members. I am Dr. Henry Fields, Chairman of the Council on Government Affairs of the American Dental Association (ADA). I am a Professor and the Division Chair of Orthodontics at The Ohio State University. I also have a private orthodontics practice and I am an attending dentist and Chief of Orthodontics at Nationwide Children's Hospital in Columbus.

The ADA, which represents 157,000 dentists, appreciates the opportunity to comment on the oral health issues that affect American Indians and Alaska Natives (AI/ANs), as well as the dentists and oral health care providers who serve in the Indian Health Service (IHS) and tribal dental programs.

The Subcommittee asked the ADA to comment on whether actions taken it has taken have helped to make a measurable reduction in the disease disparity rates between AI/ANs and all other populations and solicited recommendations on future actions the Subcommittee should consider taking within this constrained funding environment.

The ADA has been testifying before this committee since the 1990s. At that time, the dental program's budget was \$65 million. Today, it is over \$159 million. We are very grateful to the Committee for responding to the oral health care needs of AI/ANs and we have seen advances that we believe will lead to improvement in the oral health of AI/ANs. But we also know there is still much more that needs to be done.

Oral disease, especially among children, is preventable. But the level of Early Childhood Caries (ECC), tooth decay among the AI/AN children has reached epidemic proportions. The ECC prevalence is about 300 percent higher in this population than for all U.S. races. This is an important concept, because we cannot do enough fillings or afford to do enough fillings to fix the problem.

From research, we know that preventing oral disease is key and can result in savings. A study published in *Pediatrics*, the official journal of the American Academy of Pediatrics, found that children who had their first preventive dental visit by age 1 were more likely to have subsequent preventive visits and lower dentally related costs. The study also found that the earlier a child was seen by a dentist the greater the cost savings. If seen by a dentist by age 1, the average dental expenditure for a child was \$262, age 1 to 2, \$339, age 2 to 3, \$449, age 3 to 4, \$449 and age 4 to 5, \$546. A 2001 study published in the *American Journal of Public Health* found that older children who got dental sealants on their molars also resulted in Medicaid savings especially for high-risk populations.

According to the most recent data from the IHS Division of Oral Health, dentists are making advances in these areas. In 2011, the IHS placed 276,893 dental sealants, 19,632 sealants over its goal. IHS dentists reported treating 28 percent of the patients who needed care which is 5% more than they serviced in the 1990s. Additionally, the IHS reported that 161,461 AI/AN students had received at least one topical fluoride treatment. This was 25,857 applications over its goal.

The ADA believes that a key factor for these accomplishments and taking further steps to reduce disparity for disease is having a sufficient workforce. In 2009, the IHS reported needing 140 dentists. Today, the vacancies are down to 40. These numbers reflect the vacancies reported by the Division of

Oral Health and tribes that choose to notify headquarters of their openings for dentists. Because tribes are not required to report their workforce needs, the vacancy figures might be understated. Nonetheless, this data does show a substantial improvement.

We believe that the IHS summer externship program and improved loan repayment funding have contributed to reducing these workforce shortages. The IHS dental recruiters have conducted an excellent campaign to attract dental students to participate in their summer extern program as a way to introduce them to the Service. The recruiters try to make visits to at least 45 dental schools each year. These visits have resulted in over 200 third year dental students applying each year to the program. Last summer the program accepted 104 externs which resulted in 12,480 patient visits. We cannot say how many individual patients were seen as a result because in a 2-5 week externship a student may see the same patient more than once.

Experience has shown that the externs become great ambassadors when they return to school and we believe that this results in more dentists applying to the IHS upon graduation. However, one of the first things that the IHS eliminated due to the sequester was IHS staff travel. While the dental program will continue to keep recruiting through the internet and students telling others, the loss of face-to-face encounters with IHS recruiters could be a step backwards.

If recruitment visits are reduced, the Division of Oral Health would benefit from having “Direct Hire Authority” which would allow recruiters to make an offer to a viable candidate at a recruitment event. While candidates still have to go through the formal application and background check, having the ability to make an offer speeds up the hiring process and assures the candidate that they have begun the hiring process. We are aware that various divisions within the IHS use such authority, but it is unclear why the Division of Oral Health does not have the same opportunity. **We would urge the Committee to ask for a report on how the Division of Oral Health can have the same direct hire authority as other health disciplines in order to enhance future recruitments.**

The average student debt load for dentists is \$200,000 and most begin repaying their debts soon after graduation. The IHS dental loan repayment program offers an attractive incentive for dentists to join the Service. It is also an excellent retention tool for those dentists who want to continue in the IHS beyond their initial agreement. In 2012, the IHS funded all 107 applications from dentists and hygienists. Of those, 65 continued their previous contracts beyond their initial commitment which will help to maintain a continuity of care for patients.

We believe that the above data show that where an adequate workforce can be placed, there is an increase in prevention and needed treatment. While we are pleased with this utilization rate, we would like to see the IHS rates move upward to 37% for adults and 46% for children – which is the national rate. Additional investment in workforce, prevention, and oral health literacy is needed to reduce the need for treatment.

The IHS Division of Oral Health has begun to attack this epidemic with its Early Childhood Caries Initiative, a new program designed to promote prevention and early intervention of tooth decay in young children, through an interdisciplinary approach. The first step was to conduct oral health assessments of

children up to five years of age to determine the level of disease as well as the best prevention methods. The data was gathered over two years ago but the results have still not been fully and officially released. It has been ensnared in red tape between the IHS headquarters, the Department of Health and Human Services, and the Office of Management and Budget.

This delay has real consequences. The ADA and the Arizona Dental Association have been meeting for two years with local tribes in anticipation of this report. Together, they have focused on how they can join forces to drastically reduce ECC. But without these data and direction from the IHS Division of Oral Health, they cannot begin to take action. Meanwhile, the high rates of ECC continue to exist and children with the most serious disease continue to suffer in pain. We urge the Committee to encourage the IHS to follow through and release the report as soon as possible.

Anticipating that the report will be released eventually, we renew a request that we brought to the Committee's attention last year along with the Arizona Dental Association and five tribal organizations. In order for the ECC project to be successful, the Division of Oral Health needs to have full time personnel who can oversee and coordinate the national program with individual tribes, the oral health care team, medical providers, Community Health Representatives, Head Start staff, and Women, Infant, and Children (WIC) program staff. The person overseeing this program will also be responsible for ensuring that best practice approaches are followed and will coordinate the flow of prevention materials (fluoride varnishes and sealants) throughout Indian Country. Having one person to oversee this is also vital to ensuring that a uniform approach is followed by all participating entities. **We urge the Committee to provide an additional \$300,000 for needed personnel and materials.** We understand the fiscal constraints on the Committee and the IHS but not providing this funding is only going to drive up the costs of treatment. If a patient has severe tooth decay that can best be treated in a hospital under general anesthesia, the cost usually averages just over \$3,000 per visit. The anesthesia alone is over \$700. A good prevention program will avoid many of these costs and more than pay for itself.

The ADA thanks the Committee for supporting the Division of Oral Health's efforts to implement the Electronic Dental Record (EDR). For years the ADA conducted site visits to Indian country to see first-hand how IHS dental programs were functioning. We learned from those visits that patients often did not seek continuing dental care in the same facility. This makes it difficult for treating dentists to follow treatment plans. Having all IHS and tribal dental clinics connected through an EDR addresses that need. The IHS has been able so far to connect more than half of the sites but there are still almost 100 facilities that are not part of the system.

The ADA and the IHS dentists know that oral disease is preventable, especially when intervention begins at an early age. We know that because of years of underfunding, oral disease among AI/AN children and adults has far exceeded current capacity. In 2007, dental care expenditures in the United States were estimated at \$92.5 billion or \$316 per person. In contrast the 2009 budget for the IHS dental programs was \$141.9 million, approximately \$75 for each of the 1.9 million AI/ANs served by the IHS. In 2009, the ADA estimated that to bring oral health care to parity for AI/ANs the annual targeted minimum budget for the Division of Oral Health would have to rise to \$600 million.

We recognize that to reach that level of funding isn't going to happen overnight and in these constrained economic times it is necessary to augment IHS services. The ADA has conducted a program to bring volunteer dentists to Indian country to provide needed care to underserved areas. From 2006 to 2012, the ADA recruited and assigned nearly 200 volunteer dentists and dental students to IHS and tribal programs. Our volunteers found this to be very rewarding experience and we strengthened relationships with tribes.

Additionally, the ADA and several of its state societies in Indian Country have joined forces to advance oral health outreach and raise awareness. The Arizona and New Mexico Dental Associations established the ADA's Native American Oral Health Care Project to address the imbalance in access to quality oral health care among Native Americans. These organizations have made numerous visits to Indian Nations to meet and collaborate with tribal leaders. ADA presidents have met with Tribal leaders, health directors, and policy makers to discuss a comprehensive approach for improving oral health care in Indian Country. We have discussed such goals as how the ADA and tribal organizations can join forces to pool and leverage resources to enhance prevention efforts, increase access to dentures for community elders and support oral health care prevention strategies for youth.

Tribal leaders also emphasized the need to recruit American Indians into the dental profession. We are in the process of taking the first steps to establish a dental pipeline that will begin with exposing AI/AN youth to oral health care and dentistry and end with mentoring students through dental school. Having explored possible projects with universities from Massachusetts, Nebraska and Arizona, we anticipate the development of long term partnerships with tribal leaders to achieve this goal.

The ADA has also supported similar efforts between tribes in the Aberdeen area and the North and South Dakota Dental Associations. We are very encouraged by these efforts and wanted to make the committee aware of these talks. As more concrete plans develop we anticipate that there could be a need for additional resources for the Tribal nations for oral health literacy programs, prevention programs, and workforce. We hope that the Committee will support our efforts in building these public-private partnerships.

Earlier in our testimony we mentioned the need to have the report on the level of ECC for children released as soon as possible. That is the starting point for the ECC program. In 2011, the Division of Oral Health posted on its website a plan to conduct an oral health survey from 2011-2020. The proposal will measure not only the oral health of children but also adults. We were pleased to see this proposal because the last oral health survey was released in 1999 and during that time more information about oral disease has been reported.

Research funded by the National Institute of Dental and Craniofacial Research in the last 15 years has shown potential links between oral health and systemic health. They have established a connection between oral bacteria and pneumonia in nursing home patients. Cardiac surgeons are now not likely to proceed with a heart transplant if the patient has any kind of oral disease. The bacteria in the mouth can undermine such an operation. We know oral infection complicates a diabetic's ability to control the disease. Being able to eat a balanced and nutritious diet is also important for patients suffering from kidney disease, surgery or cancer. Dental problems can compromise overall health and well-being.

We are pleased that the Division of Oral Health will survey adults because the 16-20 year gap in reporting any data has made it difficult to know if oral disease patterns have changed or remained constant. The Division of Oral Health needs to know today if they are still making progress. They need to know if new treatment modalities are more effective in eradicating dental disease than in the 1990s. They also need to know how large a workforce the IHS and tribal organizations need to fully meet patients' educational, preventive and restorative needs. We strongly encourage the Committee to do what it can to urge the IHS to expedite such research. With this knowledge the IHS and its dental partners can better focus on providing more cost effective care for the greatest number of patients.

Thank you for allowing the ADA to testify and highlight the needs and successes of the IHS dental program. The ADA is committed to working with you, the IHS and the Tribes to aggressively reduce the disparity of oral disease and care that currently exists in Indian Country. We know oral disease is preventable – provided that appropriate oral health literacy programs, prevention programs and an adequate workforce are in place.