Good afternoon Chairman Calvert, Ranking Member Moran and Committee Members. I am Dr. Charles Norman, President of the American Dental Association (ADA). I am a private practicing dentist in Greensboro, North Carolina.

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.

We are pleased that the Administration has recommended an increase for the Division of Oral Health (DOH) to $175.654 million for FY 2015. The proposed funding level will allow the Division to maintain its current programs and staff new facilities but it doesn't allow it to attack the increasing incidence of oral disease – especially among AI/AN children.

The level of tooth decay among the AI/AN children (Early Childhood Caries (ECC)) has reached epidemic proportions. The latest data from the Navajo tribe shows tooth decay present in 48 percent of one year olds, 74 percent of two year olds, 85 percent of three year olds, and 94 percent of four year olds. The decay rate of Navajo children 5 years old or younger is the highest in the nation.

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. 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.

The ADA believes that a key factor for reducing oral disease is a sufficient workforce. Over 700 dentists are currently employed by the IHS but there are still 40 advertised openings for dentists. However, the actual need is much higher. The IHS advertised positions only reflect the vacancies reported by the DOH and tribes that choose to notify headquarters of their openings. Because tribes are not required to report their workforce needs, the vacancy figures are understated. We know this is true from listening sessions and Tribal partnerships that we formed in Indian country.

Several years ago, the ADA organized the Native American Oral Health Care Project to identify solutions to dental care issues facing tribes in Arizona, New Mexico, North Dakota and South Dakota. Since its inception, local tribal consultants and state executive directors have held numerous meetings throughout the states with tribal leaders in order to engage Native Americans

on access to oral care issues. Of course, all actions taken by the dental associations in these states acknowledge and support the sovereignty of all First Nations.

Those collaborations have resulted in several specific dental actions:

• The North Dakota Dental Association (NDDA) conducted "Pediatric Dental Days" in October, 2013 for the Standing Rock Sioux Tribe. Over the two day event, 367 children were seen and approximately $150,080 of donated dental services were provided.

• In 2013, the New Mexico Dental Association (NMDA) held a Mission of Mercy (MoM) project in Farmington, which borders the Navajo reservation. Over $586,000 in free care was provided to almost 1,000 patients, one quarter of whom identified themselves as American Indian.

• The Arizona Dental Association (AzDA) and NMDA have offered a "Ten Year Oral Health Plan" for incorporation within the Navajo Nation's Ten Year Health and Wellness Plan.

• The NMDA is expanding dental care through the use of Community Dental Health Coordinators (CDHCs) who bridge the gap between the existing care resources and unmet need. The NMDA is in discussions with a New Mexico Community College to incorporate the CDHC curriculum into its educational program to educate American Indian students as CDHCs. Their goal is to have a new class ready to begin in 2014.

• The SDDA, in concert with the Delta Dental Foundation of South Dakota, was awarded a CMS Healthcare Innovation Award to improve Native American oral health in 2012. The grant supported the development of a modular CDHC training program to add oral health skills and understanding to existing Community Health Workers across reservations.

• The AzDA has conducted regional roundtables with tribal representatives from 18 of the 22 Native American tribes in the state. The meetings have focused on oral health literacy, preventive programs, CDHCs, the educational pipeline, and coalition building. Additionally, the AzDA has been awarded a DentaQuest Development grant to support the work of the Native Oral Health Alliance which was founded as an outgrowth of this collaboration. One of the most tangible pipeline project possibilities is in discussion with the San Carlos Apache Tribe.

• The ADA will be offering technical assistance and curriculum support as requested by the Navajo Nation for establishment of the Association's Community Dental Health Coordinator program. Discussion is also underway for a CDHC sabbatical to take place this summer.

Increasing funding for the DOH would add to the efforts already begun by our state associations, especially by filling vacancies for dentists at Tribal and IHS facilities. But we know that if the IHS would streamline its credentialing process to make it easier for local dentists to volunteer we could ensure even more patients, especially children, receive needed care.

Last year, 30 South Dakota dentists signed up to volunteer at IHS dental clinics 1-4 days a year. All of the dentists have valid South Dakota licenses. The plan was for the state dental association to keep a master copy of every dentist's credentialing application and send it to each site when they needed a volunteer thus saving the dentist the frustration of filling out the same 20 page application over and over.

But the plan fell apart when it was learned that each site has its own unique credentialing forms. In addition to the lengthy forms, the process suffered from wasted time. Weeks would go by without any acknowledgement of an application being received or that it was filled out incorrectly. Almost everyone gave up somewhere in the process.

In the end, only two dentists actually were credentialed. When the first dentist showed up to work they took fingerprints and ran a background check. He couldn't practice there until the background check came back, so he toured the Reservation that day and treated no one.

The other dentist and his staff were helped after hours so that their background checks could be done overnight and they could work the next day. This dentist was only able to do a handful of cases over two days because the hospital had only one operating room (OR) available and only one anesthetist. Children with multiple cavities often need to be treated under general anesthesia. On two occasions the dentist was bumped from the OR due to OB cases taking priority. While we understand the situation, the result was that children in severe oral pain went untreated.

The ADA thanks the Committee for including report language in the FY 2014 omnibus bill to encourage the IHS to explore establishing a centralized credentialing system similar to those used by the Departments of Defense and Veterans Affairs. We would be glad to work with the Service in establishing a pilot program to see what improvements can be made.

Unfortunately, the IHS has not heeded the Committee's FY 2014 report language and has not contacted the ADA to determine ways to provide better and broader access to oral health care through the use of additional volunteer dentists. I respectfully request that the Committee direct the IHS to seek the assistance of the ADA in determining ways to increase access to oral health care through the recruitment and credentialing of volunteer dentists.

The ADA and its state chapters are committed to improving oral health care for AI/ANs but there also needs to be recognition that the DOH needs additional resources. Because of years of underfunding, oral disease among AI/AN children and adults has far exceeded current capacity.

In 2012, dental care expenditures in the United States reached $111 billion or $353 per capita. In contrast, the 2015 budget for the IHS dental programs of $175 million allows only $83 for each of the 2.1 million AI/ANs served by the IHS. The funding level would not cover one dental visit a year, while a majority of Americans see a dentist twice a year. To bring oral health care parity to AI/ANs the annual budget for the Division of Oral Health would have to rise above $560 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 through a variety of efforts. Specifically, we would recommend that the Committee include:

- An additional $2 million each year over the next three years for the Electronic Dental Record (EDR) program to connect the last 80 of 230 sites. In spite of previous report language from the Committee urging the IHS to spend funds on this program the Service has not complied.

- An additional $1.6 million so that the Service can expand its Dental Clinical and Preventive Support Centers (DSC) from 8 to 12 sites. The DSCs provide technical support, training and assistance regarding treatment and preventive care to tribes.

- An additional $500,000 for oral health supplies like tooth brushes and educational posters that the Tribes we have worked with indicate are badly needed by oral health professionals, health educators and community health representatives. The Tribes recognize the need for these basic resources of oral health care but they do not have sufficient funds to provide them for their people. The proposed FY 15 IHS budget also doesn't include such additions.

Thank you for allowing the American Dental Association to testify and highlight the needs of the IHS's Division of Oral Health program. The ADA is committed to working with you, the IHS and the Tribes to aggressively reduce the disparity of oral disease and to increase the level of dental care that currently exists in Indian Country. We know oral disease is preventable especially if an adequate dental workforce, individual and community-based prevention programs are in place, and an oral health literacy program supports the whole undertaking.