ADA American Dental Association®

Dr. Joseph P. Crowley, D.D.S.
President
American Dental Association

On behalf of the American Dental Association (ADA) and our 161,000 members, thank you Chairman Calvert and Ranking Member McCollum for the opportunity to testify on the oral health issues that affect American Indians and Alaska Natives (AI/ANs) and the dentists that serve in the Indian Health Service (IHS) and tribal programs. I am Dr. Joseph Crowley, President of the ADA and a practicing dentist in Cincinnati, Ohio. For fiscal year 2019, the ADA requests $199 million for the IHS Division of Oral Health.

We thank you and the Committee for the strong commitment that you have made to improve the oral health care of Native Americans. Your support for many years has resulted in improvement especially among children.

The Committee were strong backers of the dental program's Early Childhood Caries initiative, which aimed to reduce tooth decay among children under the age of five. Through this program, the IHS has been able to significantly increase prevention and early intervention for these children. The IHS reported that:

- The placement of dental sealants increased by 65%,
- The number of children receiving fluoride varnish increased by more than 68%, and
- The number of therapeutic fillings increased by 16%.

These interventions resulted in a net decrease of dental caries prevalence from 54.9% in 2010 to 52.6% in 2014. But there was an even more dramatic decrease in tooth decay from 33.4% to 27.1% in 1-2 year olds. This is one of largest decreases in caries experience reported in dental literature over such a short time span.

Wanting to build off this success, the IHS Dental Program last year held a strategic planning meeting with tribal organizations, IHS dentists, researchers, and dental organizations to further address oral health disparities among AI/ANs. The groups explored ways to apply the most recent scientific interventions and prevention methods for specific age groups. The approach and materials used for toddlers differs from those needed for teenagers.

We were heartened by this meeting and look forward to working with the IHS and tribal organizations to implement the ideas and approaches put forth in the meeting as there is still more to overcome to erase the disparity of oral disease. This includes the innovative work being done surrounding the use of silver nitrate and silver diamine fluoride as secondary prevention measures to early childhood caries as evidenced by the work being done by Dr. Frank Mendoza on the Warm Springs Indian Reservation in Oregon, who received an ADA Presidential Citation for these efforts in 2017.

Over 80% of AI/AN children ages 6-9 and 13-15 years old suffer from dental caries, while less than 50% of the U.S. population in the same age groups have experienced cavities. It isn't just

AI/AN children who suffer from oral disease. AI/AN adults have more than double the prevalence of untreated tooth decay as the general U.S. population. Native American adults also have double the rate of severe periodontal disease than the general U.S. population.

The most critical account in the Administration's FY 19 IHS dental program budget is for clinical services. This funding is used to provide direct dental services, diagnostic, emergency, preventive and simple and complex restorative care.

The Administration is proposing an increase of only $1,728,000. This request is unrealistic to significantly reduce oral disease in Indian Country. In FY 2017, the IHS dental program provided 3,828,214 basic dental services through 1,371,172 dental visits in 404 dental programs in 35 states. The Administration's FY 19 request would be less than $1.00 per visit. The ADA recommends that the IHS dental clinical services line be increased by at least $3 million.

The eight Dental Support Centers (DSCs) are an integral component of the IHS dental program. While they do not provide direct dental care, their primary purpose is to provide technical support, training and assistance in clinical and preventive aspects of the dental programs. Many IHS dentists practice in isolated areas without immediate access to specialty services. A good number of these dentists are just beginning their professional careers. These Dental Support Centers provide them with the necessary expertise and experience they need to best address the challenging oral health demands presented before them.

The Support Centers have been instrumental in tracking the incidence of prevention procedures AI/ANs receive. Several DSCs provided oral health education materials or designed materials customized to the specific needs of the tribes they serve. Since being established in 1999, the IHS has only been able to support DSCs in 8 of the 12 IHS service areas. Their funding has been frozen at $250,000 throughout that time. To reach all 12 areas and increase their support to $350,000, the ADA request funding for the DSCs be increased by $2.5 million.

The ADA applauds the IHS for its excellent dentist recruitment program that begins by focusing on dental students. Each year the IHS offers an externship program to third year dental students. In 2016, 115 students were placed in 23 different sites. They were recruited from 34 of the 62 U.S. dental schools. Since the program's inception 18 years ago, it has produced approximately 6,000 applicants with 2,000 externs selected. To extend their reach among dental students, the IHS is working to build a presence on social media through Facebook and LinkedIn to create recruitment multipliers. Also, those 2,000 externs selected now serve as ambassadors who currently work at IHS and other public health settings, in private practice and academia. These ambassadors are the best recruiters because they share their stories with others. Due in great part to their efforts, 63% of the dentists hired in recent years were influenced by the externship program.

Despite the success of the extern program and other recruitment efforts, the dental vacancy rate in the IHS hovers around 20%. Dentists have one of the highest student loan rates, averaging more than $250,000. The IHS loan repayment program has proven to be an excellent mechanism for recruitment and retention.

However, there are more dentists who are willing to serve in the IHS than there is loan repayment. In FY 2017, 18 dentists were turned down for loan repayment. The IHS reports that overall 788 health care providers were turned down for loan repayment. The Service estimates that it would take an additional $39 million to meet these requests. Yet, the Administration is recommending that this account be decreased by almost $6 million in FY 19. We strongly urge the Committee to ignore the Administration's proposal and instead work to fund the requests by committing to an increase of $8 million each year for 5 years.

For many years, this Committee has supported installing an electronic dental record system for the Service. We thank you and are pleased to tell you that 235 dental centers have been brought into the system. But because this effort was begun 10 years ago, funding will continue to be needed for upgrades. Additionally, dentists would like to be linked into the IHS medical record system to allow for greater patient-centered interdisciplinary health care. This would also allow dentists and pharmacists to communicate regarding opioid prescriptions for oral pain. It would be a vital addition for addressing the opioid crisis in Indian country which is double the rate of the rest of the nation. The IHS dental program estimates that it would need an additional $1 million each year for 5 years to make such upgrades to the current electronic record system.

The ADA is pleased that the IHS is making progress on developing a centralized credentialing system and we thank the Committee for supporting this effort. According to the IHS FY 19 budget justification, the credentialing software has been implemented across all IHS Direct Service Areas as of January 31, 2018. This will streamline the credentialing process and help fill dental vacancies with quality healthcare professionals in a timely, efficient manner. The Office for Quality Health Care in the IHS oversees this program and adequate funding is needed to ensure efficiency in further implementation, consistency and uniformity in application across service units and quality management in continued use of the new credentialing system. The ADA also encourages IHS to develop procedures in order to centralize privileging across service units for health care providers who want to volunteer their services.

In 2012, the South Dakota Dental Association (SDDA), working with Delta Dental of South Dakota, made a serious attempt at placing volunteers in IHS dental clinics. The SDDA surveyed its membership of 400 practicing dentists and approximately 70 indicated a willingness to volunteer or contract with IHS. All of these dentists were sent the IHS credentialing packet and the instructions needed to complete them. Due in part to the fact that the packet is quite large and intimidating for the uninitiated, out of the 70 dentists who indicated interest in volunteering ultimately only two members, both pediatric dentists, became credentialed to work in an IHS facility. SDDA ultimately abandoned this project and established a partnership with the Jesuit Mission on the Rosebud Reservation, just eight miles down the road from the facility where the two pediatric dentists volunteered. In order to volunteer at the Mission, dentists must only have a current license to practice dentistry in South Dakota or, if they are from outside of the state, obtain a volunteer license issued by the South Dakota State Board of Dentistry. Of course, private charities are not subject to the same quality control constraints as those placed on federal facilities. This example is cited merely as a means of showing that many dentists are more than willing to help address the oral health care needs of the AI/AN population and that streamlining and centralizing the privileging process will facilitate those efforts.

Having more dentists available to provide care will also greatly enhance access to oral health services through the utilization of existing resources. The ADA is encouraging and assisting the Navajo Community Health Representative (CHR) Outreach Program to produce a guide to adding an oral health component to the CHR existing work across the lifespan, thus further integrating oral health into overall health for better outcomes. Other Arizona tribes (approximately 21) have asked for this technical assistance. The Administration's proposal to discontinue the CHR outreach program undermines efforts to expand integrated access to overall health care in tribal communities.

Utilizing both the *Smiles for Life* oral health curriculum and educating a number of Navajo CHRs and dental assistants with Community Dental Health Coordinator (CDHC) certification will enable greater community outreach, community education and preventive services. The role of the CDHC is threefold: educating individuals and the community about the importance of oral health to overall health across the lifespan; providing limited preventive services, such as fluoride varnish and dental sealants; and connecting the community to oral health teams that can provide needed dental treatment. 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.

There are currently 16 CDHCs working in tribal facilities, including clinics serving the Chickasaw Nation Division of Oral Health, Wewoka Indian Health, and the Muskogee Nation in the Oklahoma City area. More are currently in training to serve the tribal community.

Mr. Chairman, thank you for this opportunity to share with you and the members of the Subcommittee the oral health issues that affect American Indians and Alaska Natives and the dentists that serve in the Indian Health Service and tribal programs. We look forward to working with the Subcommittee to address these concerns.