THE PEW CHARITABLE TRUSTS

2005 Market Street, Suite 1700 215.575.9050 Phone
Philadelphia, PA 19103-7077 215.575.4939 Fax

901 E Street NW, 10th Floor 202.552.2000 Phone
Washington, DC 20004 202.552.2299 Fax
www.pewtrusts.org

Shelly Gehshan
Director, Pew Children's Dental Campaign
sgehshan@pewtrusts.org

Testimony of the Pew Children's Dental Campaign
Regarding Fiscal Year 2015 Appropriations
Submitted to the
U.S. House of Representatives Committee on Appropriations
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

On behalf of the Pew Children's Dental Campaign, thank you for the opportunity to submit testimony regarding appropriations for Fiscal Year (FY) 2015. We appreciate the subcommittee's recognition of oral health as a key aspect of overall health and its continued support of programs that expand access to preventive and restorative services through the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC).

The Pew Children's Dental Campaign works at the state and national levels to ensure that more children receive dental care and benefit from evidence-based policies, such as community water fluoridation, dental sealant programs, and expansion of the dental workforce. Since it was established in 2008, our initiative has produced numerous reports evaluating access to care across the 50 states and the District of Columbia, and while we have made significant progress in advancing reforms nationally and in the states, there is still much to be done on this important issue.

Tooth decay affects nearly 60 percent of the nation's children, and, unsurprisingly, its consequences are concentrated disproportionately among low-income children.[i] Dental disease is the most common chronic disease among children in the U.S.—five times more prevalent than asthma, and in a single year, U.S. students may miss as many as 51 million hours of school due to dental health problems.[ii] It causes pain, hampers school performance, and if left untreated can lead to tooth loss and abscesses that spread infection to the blood and brain.[iii]

Lack of access to preventive services and oral health care also imposes a huge cost on states. In 2011, preventable dental conditions were the primary reason for 857, 712 emergency room (ER) visits in the U.S.[iv] In 2010, Florida spent more than $88 million on more than 115,000 hospital ER visits for dental problems and in 2007, 60,000 dental visits to ERs cost the state of Georgia more than $23 million.[vvi] Dental problems can also impact the workforce, causing an estimated 164 million hours of lost work time each year, and can inhibit a person's ability to find a job.[vii] Additionally, a 2008 study of the armed forces found that 52 percent of new recruits were found

to be Class 3 in "dental readiness," meaning they had oral health problems that needed urgent attention and would delay overseas deployment.[viii]

Given the enormous impact of oral health on overall health and the associated social and economic consequences, we respectfully request that the subcommittee consider the following appropriations requests for programs that aim to expand access to care and preventive services for those most in need.

Focusing on prevention

With support from the CDC Division of Oral Health, states can better promote oral health and efficiently administer scarce resources, monitor oral health status and problems, and conduct and evaluate prevention programs through cooperative agreements. This funding is critical to a state's ability to prevent problems before they occur, rather than treating them when they are painful and expensive. The cooperative agreement program also supports state community water fluoridation programs and school-based dental sealant programs, and while funding for this program has been authorized for all 50 states, the Division is currently only able to support 21 states: Colorado, Connecticut, Georgia, Hawaii, Idaho, Iowa, Kansas, Louisiana, Maryland, Michigan, Minnesota, Mississippi, New Hampshire, New York, North Dakota, Rhode Island, South Carolina, Vermont, Virginia, West Virginia, and Wisconsin.

Research shows that community water fluoridation offers one of the greatest returns on investment of any preventive health care strategy. For most cities, every $1 invested in water fluoridation saves $38 in dental treatment costs.[ix] CDC estimates that fluoridated water saves more than $4.6 billion annually in dental costs in the United States,[x] and even more could be saved by expanding coverage to some of the 70 million people who still do not have it.[xi] Dental sealants are also cost-effective; school-based programs can efficiently prevent 60% of decay in the permanent teeth most likely to become decayed during childhood.[xii] We recommend a funding level sufficient to enable all states and the District of Columbia to receive the critical CDC prevention funds, starting with an increase for the coming fiscal year to begin moving toward full funding.

Funding request for FY 2015: $19 million for the CDC Division of Oral Health to expand cooperative agreements to additional states

Addressing the dental access crisis

Pew's 2013 brief, *In Search of Dental Care*, found that roughly 45 million Americans live in dental professional shortage areas, regions that have a scarcity of dentists relative to the population.[xiii] Additionally, in 2011, more than 14 million children enrolled in Medicaid did not receive any dental service, in part due to the low numbers of dentist participation in the Medicaid program.[xiv] The supply of dentists nationally is also likely to shrink in the coming years. The American Dental Association projects that despite the addition of new dental schools and

possible increase in graduates, between 2010 and 2030 the ratio of dentists to Americans will continue to fall due to high numbers of dentists approaching retirement age.[xv]

Many states are expanding scope of practice laws to enable a variety of dental care providers to expand access to care to the underserved, such as dental therapists in Minnesota and Alaska tribal lands, public health hygienists in Kentucky, Maryland, and New Hampshire, and community dental health coordinators in Arizona, California, Montana, New Mexico, Oklahoma, and Wisconsin. A federal demonstration grant program authorized in 2010 but currently unfunded would provide training institutions, community health centers, public hospitals, and other organizations with funding to train these types of providers, all in accordance with state scope of practice laws, and evaluate their impact on access to care.[xvi] Also eligible for funding through this demonstration are programs such as one in California that uses telehealth services to bring care to patients in Head Start centers and nursing homes[xvii] and ER diversion programs that link public hospitals to federally qualified health centers.[xviii]

Pilot efforts to assess how new dental providers can increase access to care are being developed in Oregon, Michigan, Connecticut and Hawaii, and Maine, Kansas, New Mexico, Ohio, and Washington are among the states considering legislation to authorize dental therapists. These providers and programs can increase access at a lower cost to states, and numerous studies have reaffirmed the quality of the services being provided.[xix] These evaluations would not only benefit those states that have authorized alternative providers, but would also provide information to inform policies in the many other states that are struggling to find answers to the challenge of expanding access to the underserved.

HRSA funding request for FY 2015:

- **Removal of the current funding block on existing funding for the Alternative Dental Health Care Provider Demonstration Grants, Section 340G-1 of the Public Health Service Act, and an appropriation of $10 million to initiate the program**
- **$32 million for Title VII program grants to expand and educate the dental workforce**

By making targeted federal investments in effective policy approaches, the subcommittee can enable states to sustain programs that prevent the pain, missed school hours and long-term health and economic consequences of untreated dental disease. A handful of states are leading the way, but all states can and must do more to ensure access to dental care for those who need it most. Thank you for your consideration of this testimony.

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[i] U.S. Department of Health and Human Services, *Oral Health in America: A Report of the Surgeon General*, DHHS, Rockville, MD, 2000.
[ii] Ibid.
[iii] Ibid.
[iv] HCUPnet, Healthcare Cost and Utilization Project, "Information on ED visits from the HCUP Nationwide Emergency Department Sample (NEDS)," Agency for Healthcare Research and Quality, Rockville, MD. http://hcupnet.ahrq.gov/
[v] "315 Patients a Day Seek Dental Treatment in Florida's Hospital Emergency Rooms," a news release by the Florida Public Health Institute, (December 15, 2011).

[vi] Andy Miller, "Fight over Georgia dental rules flares again," *Georgia Health News*, September 7, 2011, http://www.georgiahealthnews.com/2011/09/fight-dental-rules-flares/.
[vii] U.S. Department of Health and Human Services, *Oral Health in America: A Report of the Surgeon General*, DHHS, Rockville, MD, 2000.
[viii] T. M. Leiendecker, G. C. Martin et al., "2008 DOD Recruit Oral Health Survey: A Report on Clinical Findings and Treatment Need," Tri-Service Center for Oral Health Studies (2008), 1.
[ix] Centers for Disease Control and Prevention, "Cost Savings of Community Water Fluoridation," Fact Sheet, Accessed March 27, 2014: http://www.cdc.gov/fluoridation/factsheets/cost.htm
[x] Centers for Disease Control and Prevention, "Preventing Dental Caries with Community Programs," Fact Sheet, Accessed March 27, 2014: http://www.cdc.gov/oralhealth/publications/factsheets/dental_caries.htm
[xi] Centers for Disease Control and Prevention, "2012 Water Fluoridation Statistics," Data and Statistics, Accessed March 27, 2014: http://www.cdc.gov/fluoridation/statistics/2012stats.htm
[xii] Truman, B. I., Gooch, B. F., Sulemana, I., Gift, H. C., Horowitz, A. M., Evans, C. A., et al. (2002). Reviews of evidence on interventions to prevent dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries. American Journal of Preventive Medicine, 23(1 Suppl.), 21–54.
[xiii] The Pew Charitable Trusts, "In Search of Dental Care," June 2013, http://www.pewstates.org/uploadedFiles/PCS_Assets/2013/In_search_of_dental_care.pdf
[xiv] This figure counts children ages 1 to 18 eligible for the Early and Periodic Screening, Diagnostic and Treatment Benefit. See U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Annual EPSDT Participation Report, Form CMS-416 (National) Fiscal Year: 2011*, April 1, 2013. Analysis by The Pew Charitable Trusts; U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Early and Periodic Screening, Detection and Treatment Web page (accessed May 24, 2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/ Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html.
[xv] American Dental Association, Health Policy Resources Center, *2011 American Dental Association Workforce Model: 2009-2030* (Chicago: American Dental Association, 2011), 11.
[xvi] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, sec. 5304, 124 Stat. 119, 621-622 (2010).
[xvii] Virtual Dental Home Demonstration Project, Arthur A. Dugoni School of Dentistry, University of the Pacific: http://www.dental.pacific.edu/Community_Involvement/Pacific_Center_for_Special_Care_(PCSC)/Innovations_Center/Virtual_Dental_Home_Demonstration_Project.html
[xviii] Centers for Medicare and Medicaid Services, "Emergency Room Diversion Grant Program," 2008- 2011, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/ER-Diversion-Grants.html .
[xix] David A. Nash et al., *A Review of the Global Literature on Dental Therapists*, April 2012, W.K. Kellogg Foundation, http://www.wkkf.org/knowledge-center/resources/2012/04/nash-dental-therapist-literaturereview.aspx.