



Oral Health: Putting Teeth into the Health Care System
Alliance for Health Reform
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EDWARD F. HOWARD, JD: Alright. Why don't we try to get started? My name is Ed Howard. I'm with the Alliance for Health Reform. On behalf of Senator Rockefeller, our honorary chairman, and our board of directors, I want to welcome you to this program about a very much neglected aspect of health and health policy in the United States. That is oral health.

Now you've probably heard and will hear more today about the fact that the most common childhood disease in the United States is dental caries or cavities. Poor oral health is linked to serious physical conditions like diabetes and heart disease, but that connection is not very widely recognized. In fact I was listening to a presentation about dental needs a week or two ago and the speaker felt compelled to remind the audience, and these are her words, "The mouth is part of the body."

Now we've had a lot of reminders about the sorry state of oral health in America from the Institute of Medicine, from GAO, from former Surgeon General David Satcher, from former HHS Secretary Lou Sullivan, from the Kellogg Foundation, and from RWJ. In short plenty of documentation of gaps in our current system. Today we're going to try to update that story; take a fresh look at both the problem and at some policy options being considered to deal with it.

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Now as we were talking just before the program started, nobody is more pleased than Jay Rockefeller, our honorary chairman, that we're discussing this topic today. There's a story that he tells about coming to the little town of Emmons, West Virginia as a VISTA worker back in 1964. I actually had someone in our office transcribe what he said a couple of months ago in describing that experience. These are his words.

"When I arrived in Emmons, I was shocked to learn that there was absolutely nothing school-age children living there could get in the way of dental care. They'd never been to a dentist, never heard of dentist. There were no dental services available. You saw teenagers whose mouths were already beginning to go bad. We worked to get a bus to bring children to this grade school in Charleston to receive dental care. I remember that after the dentist checked some of those young teenagers over, he said, 'Jay, it's a nice thing for you to do for them, but it really is much too late. If you don't get the baby teeth right, anything else that follows is going to be bad and get worse.'"

The senator has been working on dental access issues ever since, and the Alliance is proud to focus on those program problems today at this briefing. We are very pleased to have as a partner in that briefing the Robert Wood Johnson Foundation, which has been helping America enjoy healthier lives and get

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the care they need for 40 years. I have a button to prove that. You can't see it, but it says 40.

Thanks very much to Dr. David Krol and his colleagues at the Foundation for their help in thinking through this topic and helping to pull the briefing together. David Krol is a pediatrician. He's a Team Director and Senior Program Officer for human capital at the Robert Wood Johnson Foundation. We're very pleased to have him co-moderating today's briefing. David?

DAVID M. KROL, MD, MPH, FAAP: Thanks Ed, and thanks to you all from the Robert Wood Johnson Foundation for coming today. We really appreciate that the Alliance is taking on this topic and that you're all interested in this topic. Oral health is an integral part of overall health. Now if we believe that to be true, and I do, that seemingly ho-hum statement holds within it an abundance of challenges and opportunities. The challenges in many ways as the statement says are the same as overall health.

There are racial, ethnic, geographic disparities of disease and access to care. There are financing challenges. There are issues of determining and maintaining quality of care, and there are workforce controversies just like overall health. The opportunities, however, are great. One really great opportunity, and I'd really like to see it, is that all

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conversations on health and health care will naturally include oral health.

While we've taken the time to have a specific Alliance forum on oral health, it would be really nice to see future Alliance forums that talk about Medicaid, talk about financing, fill in the blank. Remember that oral health is a part of that. Oftentimes it's forgotten. Not just by the Alliance, but even by our Foundation at times. As we continue to recognize that factors influencing health are expressed at individual and community levels, we can develop legislative, regulatory, educational, and clinical policies to improve oral health and health care.

Another opportunity is that funding schemes for prevention and treatment of disease will naturally include oral health. I think that's important for us to remember. Right now we fail pretty miserably in Medicare, where we don't have coverage for dental disease and dental services. You can argue that there is some coverage in certain parts of Medicare, but we don't do as good a job as we should.

Then finally and perhaps most importantly—and I think something if you learn nothing from me today, it's this: That there's a great opportunity in remembering that all makes and models of patients, providers, and policy makers can play a role in improving oral health. I just hope that you'll leave

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the forum with that in mind as you go out into your work, whether it be as a policy maker, a policy influencer, a patient, or a provider for those patients. Thanks very much for your time, and I'll enjoy listening to the rest of this forum.

EDWARD F. HOWARD, JD: That's great. Thank you very much, Dave. A couple of logistical items: There's a lot of good information in your packets including biographical information about all of our speakers. There's a sheet that lists additional resources that you can use for further edification. All of that is also online at our website, www.allhealth.org. As of Monday you will be able to look at a webcast of this briefing on the website of the Kaiser Family Foundation, which we're grateful to for providing that support.

There will be a transcript available in a week or so on our website. If you're watching on CSPAN at the moment, you can go to the Alliance website that's www.allhealth.org. You'll see the presentations and the rest of the background material if you happen to have access to a computer at the same time. You can see on the slide behind me that there is Tweeting going on about this briefing and at this briefing with the hashtag oral health if you care to join in in one way or another.

I want to get to the program now. We have a great lineup of folks with a lot of different experiences to share with you as soon as I get to my proper space in the notes. I

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will introduce our initial speaker, Lynn Mouden. Dr. Lynn Mouden—I'm sorry. Yes, is a dentist and chief—I got confused because we had shuffled the order. I had—you don't care why I did that actually. I'm going to stop and just say that Lynn Mouden is a dentist and the Chief Dental Officer for the Centers for Medicare and Medicaid Services.

He is a founder of the Prevent Abuse and Neglect through Dental Awareness programs, felicitous acronym PANDA. Before joining CMS, Dr. Mouden spent 16 years in private practice, 20 years in state health departments. He's a past President of the Association of State and Territorial Dental Directors and serves as the American Dental Association's National Spokesperson on family violence prevention. We're very pleased to have you here with us today, Dr. Mouden.

LYNN MOUDEN, DDS, MPH: Thank you, Ed. I think you're the keeper of the clicker.

EDWARD F. HOWARD, JD: I am.

LYNN MOUDEN, DDS, MPH: Thank you. I certainly want to thank the Alliance and Robert Wood Johnson for putting together this briefing today. It gives us a chance not only to highlight oral health issues, but also to talk about some of our successes. I am sure many of you have talked about the CMS triple aim of better health, better health care, and reduced costs. This particular briefing gives a chance not only to

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address the triple aim, but to show how oral health is making great inroads into addressing those.

CMS has an oral health initiative. We have two goals that are specific to dentistry, the first being that we will increase by 10 percentage points the proportion of Medicaid and CHIP children who have received a preventive dental service in a year. Now it's interesting to note that that is 10 percentage points, not 10 percent. It doesn't mean going from 20 percent to 22 percent. It would mean for example going from 20 percent to 30 percent.

It's not only a national goal, but it's a goal that we have set for each of the states. This information is based on what we know as the CMS Form-416 reporting EPSDT data in the states. The baseline here for this particular goal is 2011. We anticipate that we will be addressing this goal hopefully, nationally and in the states, by 2015.

The second goal is to increase by 10 percentage points the proportion of these children who receive a dental sealant on a permanent molar tooth. As you will hear other speakers talk about today, I am sure you understand that the combination of dental sealants on appropriate children and community water fluoridation can prevent virtually all tooth decay in children. We have set this again as our 10 percentage point goal for the nation and for the states.

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We will be phasing in this particular as the data comes in for this year. The CMS oral health strategy will help address these two particular goals. First of all, we have the opportunity to work with states on developing an oral health action plan, and we'll talk more about that in a minute. It's my pleasure that I get to work with the various states in their Medicaid and CHIP programs in providing technical assistance and peer-to-peer learning as they develop these action plans and move forward in addressing the two goals.

We obviously work a great deal in outreach to providers. Without the providers there is no oral health care. We're also working on outreach to beneficiaries. In fact, we'll be having the second CMS learning lab, an oral health webinar, dealing with outreach to beneficiaries, and some successful programs that will be held September, 26 at 2 p.m. Eastern time. My contact information is available at the end. If you want more information at the webinar, please contact me.

We also get the opportunity to work with our many other partners in Health and Human Services not only through what's called the Oral Health Coordinating Committee, but also in various other issues and programs as we work with our partners in HRSA, CDC, FDA, Indian Health Service, and the list goes on and on of all of us who are working toward oral health issues. The state action plans that we're asking the states to develop

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on a voluntary basis to help us address the oral health issues, we're asking them to do this action plan and hopefully to address both of the goals by 2015.

Obviously stakeholder participation is extremely critical to this process. Addressing these goals is not something that a Medicaid state agency can do on its own. It requires bringing in all the state partners, all the advocates, all of those who are interested in improving oral health for our children. We're going to be aligning efforts not just through this state action plan but also through state oral health plans, which most of the states have developed; some of them at the behest of the Centers for Disease Control and Prevention Division of Oral Health if they have that funding.

There of course are Healthy People 2020 goals. We're fortunate that each iteration of the Healthy People goals continues to have issues that address oral health for children and adults. We also work pretty closely with our partners at HRSA and the Maternal and Child Health Bureau as they work on their performance indicators, again, addressing oral health in the states. The action plan template that we've produced, offering to the states as they develop their action plan, has several different parts to it that will help us get to not only describing what's going on addressing the issues but also in how we can make these improvements.

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First of all, we're asking the states to identify existing access issues and barriers. We of course understand that every state is different. There is no way to develop a national action plan as each of the states works their individual issues, their individual problems, their individual resources, and frankly their individual politics. We want them to describe in detail the state's existing oral health delivery system and providing data on providers. That's not only dentists, but also non-dentists as well.

We obviously appreciate the contribution of dental hygienists and other members of the dental team. We also recognize the fact that there are some oral health services that can be provided in physicians' offices as well when we're talking specifically about fluoride varnish application and risk assessment on young children. We want the states to talk about what they have done for oral health improvement, things that they have done, the results, their analysis, and their evaluation of the effectiveness of their programs.

We want to know what succeeded and we also want to know what may not have been quite so successful. We would ask that the states compare their, again, Form-416 data against HEDIS measures, which talk about—the HEDIS measures talk about whether a person has had an annual dental visit. Reimbursement rates are always at the top of the discussion. I was a Medicaid

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dentist for many years in private practice. I know what it's like to get paid 23 cents on the dollar to provide care for these patients. I know that state budgets continue to be an issue as we're funding Medicaid treatment and delivery.

But by the same token, I think there are some things that can be done at the state and national level that will help address these issues. Specifically when we start talking about eliminating administrative barriers, it makes it easier for dentists to participate in Medicaid. We want the states in their action plan to talk about what they've done to address specifically the placement of dental sealants, again a proven method for preventing tooth decay; to describe their collaboration with dental schools, dental hygiene programs—because again, without the providers there is no dental care—and finally to describe the status of the use of electronic health records.

Electronic dental records are a little slower in coming on, but we know under the provisions of the Affordable Care Act that we will be moving closer and closer to electronic health records. What might they do to address these specific goals? First of all, we want them to describe the activities that are underway or planned for implementation; to describe these goals and how they're going to achieve them; providing specific details on these activities, which of course then will give us

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the opportunity to share that information with other state programs as well; and again to describe barriers to success.

Not everything we try always works 100 percent, and that's all part of the learning process. These lessons learned can be extremely valuable as other state programs work to either model what has been done or take on that issue and modify it to their own uses. The template actually provides some examples of some successful programs.

Things about reconfiguring reimbursement rates, which is not necessarily the same as increasing rates; reducing administrative barriers; showing some of the state examples where they have done exactly that; and a chance to develop and improve collaboration and partnerships because state Medicaid programs don't work in isolation. They work along with all the other partners in a state that are also addressing oral health issues. The technical support that we're providing from CMS to help address these goals and the state action plans: Working with them specifically on their partnerships and collaborations.

I had the opportunity to visit with one of the state programs just this last week, who has taken on the initiative of building a state oral health coalition in a state where one does not exist. We have an opportunity through the partnership for alignment project, which I'll go ahead and tell you has

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often been called the sand box project because we know that people want to learn to play well in the sand box together. But not making light of it, this project is an effort that will put public health programs and state Medicaid programs in closer partnership and collaboration to share the resources, to share the ideas, to share the ways that they can improve access to oral health for children.

We're working with the Medicaid-CHIP State Dental Association (MSDA) on a best-practices project, a formal process with criteria and grading not to just recognize promising programs, but going through a rigorous evaluation to decide what are in fact best practices for state Medicaid programs. We're working with the states to connect one state with another to share these successful models. I was asked to highlight one part of the Affordable Care Act which talks about the demonstrations projects for alternative dental healthcare providers.

Part of Section 5304 talks about community dental health coordinators, advanced practice dental hygienists. You can read the list. I don't need to go through it because we all realize that there are issues of access to dental care in every state. There are parts of the population who have an extremely if not impossible time accessing dental care. We need to be

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looking at these various other models that may be useful in addressing these access issues.

What the Affordable Care Act does is call for demonstration projects where these different models would actually be proven one way or the other. There is in the Act a list of eligible entities. It obviously includes higher education dental schools, health departments and such, and does specifically say that these programs must be accredited by the Commission on Dental Accreditation, which accredits all dental and dental hygiene programs in the country.

I appreciate the chance to talk about all these issues and what CMS is doing to address them. Please feel free to contact us any time as you work either at the national level or at the state level as we all work to improve oral health for children and, yes, for adults and the elderly. Thank you.

EDWARD F. HOWARD, JD: Thanks very much, Lynn. Now we're going to turn to Dr. Monica Hebl. Dr. Hebl practices general dentistry in Milwaukee, and she is the elected chair of the American Dental Association's Council on Access, Prevention, and Interprofessional Relations. She is also a past President of the Wisconsin Dental Association, and she's been involved for her entire career in extending access to dental services for underserved populations. Thanks for being with us, Dr. Hebl.

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MONICA HEBL, DDS: Thank you very much for allowing me to address you this afternoon. As you've already heard, oral health often takes a back seat to medical. Good oral health is integral to overall health. I appreciate the time you're taking to learn about oral health issues. It'll take a paradigm shift for oral health to gain enough support from enough sectors to achieve lasting improvements in optimal oral health for all. The ADA is working hard to build momentum and increase the focus on oral health issues by partnering with many groups and organizations involved in oral health.

You just heard a little bit about my background, but I'd just like to put a little flavor on it, local flavor. I am a private practicing dentist, so this is an unusual experience for me; a little nervous. I got involved in dentistry as a 14-year-old dental assistant in my mentor's office, Dr. Stanley Donohoo. I still work in that same practice along with his son and my brother-in-law.

In 2000, we moved from our central city location to the northwest side of the city. We chose to remain on three bus lines so we could continue our mission to continue Dr. Stan's legacy of taking care of those in need. We devote about a third of our time to medical assistance even though it's economically challenging. We also participate in charity care programs.

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I've been involved in organized dentistry since I graduated from dental school, and I've worked tirelessly to improve access to dental care for the underserved. It's a difficult, complex problem that requires activity on multiple fronts. There is no silver bullet to solving access. Poverty; geography; lack of oral health education and transportation; language and cultural barriers, here of dental care; and the belief that people who aren't in pain don't need to seek care are some of the factors that affect a person's ability to access care.

It will take a collaborative approach of all stakeholders to improve the nation's oral health. ADA has many programs and activities to address the access issue. Recently we made it a priority to collaborate with others to leverage our activities for greater gains. I'm going to highlight a few of these programs. The CDC named community water fluoridation one of the 10 most-significant public health achievements of the past century. The cost savings and decrease in disease due to fluoride are significant. It's unfortunate that we are spending so much time and energy fighting for such a great public health measure.

We've worked with state and local dental societies, as well as Pew as you'll hear, to ensure that high-quality scientific information is available to those that are fighting

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for fluoride on a local level. Here's a map that shows you just how hot this topic is. Forty-three states have some type of fluoridation activity, and a lot of it is protecting it. Even though Medicaid programs are chronically underfunded, efforts to improve access by streamlining the administrative processes of Medicaid programs have achieved increased access for patients and participation by dentists.

States that have successfully improved their Medicaid programs usually have many stakeholders working together, and by doing so they achieve greater gains in access. CMS: We are thankful for that focus and help. Collaborative efforts that include increased reimbursement, education, care that is ongoing instead of episodic and involve public-private partnerships yield the greatest results. Each state Medicaid program is different, and each state has different issues to solve.

Here are a few examples of reforms that demonstrate gains in access, but I'm only going to highlight one due to time constraints. Michigan's Healthy Kids Dental is a partnership between a state dental association and a commercial dental plan. The streamlined administration and reimbursement is the same as the commercial plan. Access for kids enrolled is approximately 70-percent for seven to ten year olds, in stark

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contrast to the counties where the Healthy Kids Dental program does not exist.

Efforts to expand the program are underway. There are many volunteer programs that ADA member dentists are involved in throughout the year. We recognize that volunteer programs are not an adequate health care system due to their episodic nature. Therefore in 2006, our Give-Kids-a-Smile efforts changed from providing care on one day to establishing a dental home. ADA is increasingly involved in interprofessional activities because we realize the advantages of expanding the number of health professionals capable of assessing oral health and the importance of linking dental and medical homes in an effort to reach kids before they have the disease.

There is increasing activity across the country in the area of ER utilization due to the potential cost savings. One successful program, again in Michigan in Calhoun County, is modeled after Habitat for Humanity. Dentists provide care free of charge for low-income individuals who perform community service. This has led to lower costs for hospitals in the area, and it is a win-win-win for the community.

At its essence, oral health education is prevention at the most effective level and has the greatest potential to yield the best results in improved oral health. It is proud to be a part of the partnership for Healthy Mouths, Healthy Lives.

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It's a one-of-a-kind national coalition that has resulted in a launch this week of an ad council campaign with an oral health message. You'll begin to see the messages encouraging brushing two minutes twice a day. The ad council has other successful messages you might remember. Smokey the Bear and the crash test dummies. It really is exciting that it's an oral health message for the first time, and we're very excited to see the results.

We are in the evaluation stage of our pilot to create a Community Dental Health Coordinator. This new dental team member is a different approach, and it's modeled after community health workers. The goal of this new team member is to break down the many barriers for patients and provide a link between the patient and the dentist. They will educate patients and help them navigate the system in addition to tasks like helping them find a dental home, secure childcare, and arrange transportation. They will also be able to provide limited, mainly preventive services rather than focus on treating disease.

The CDHC is based on some of the ADA's key principles of breaking down barriers to care: education, disease prevention, and maximizing the existing system. In addition to the ADA website, we are launching a website for the public. The URL is www.mouthhealthy.org. I'd like to thank you very much

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for allowing me to be a part of this panel. We look forward to working together on initiatives moving forward.

EDWARD F. HOWARD, JD: Thanks very much, Monica. We're going to go now to Julie Stitzel, who is a manager for the Children's Dental Campaign of the Pew Center on the states where she focuses on workforce issues. Pew, as you have heard in the references by our first two speakers, directed a really heavy amount of attention toward improving kids' access to oral health services. They've issued several important reports including a state-by-state evaluation of how well kids' oral health needs are being met. I'm very pleased to have Julie representing that program with us today.

JULIE STITZEL, MPA: Thanks, Ed. As I've mentioned and you've heard repeatedly, dental care is the single greatest health need among children in the US, five times more prevalent than asthma. A lot of times when we're talking about health care reform, we focus on medical. It's important to focus on dental as well.

Our research and advocacy efforts focus on four efficient cost-effective strategies. One is ensuring that Medicaid and the Children's Health Insurance Program work better for kids and for providers to make sure that insurance translates into real care. The second is community water fluoridation. The third is increasing sealant programs for kids

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who need it most. The fourth is expanding the number of professionals who can provide high-quality dental care to low-income kids.

As I've mentioned, a lot of you might be familiar with our work. We released two state reports that essentially used eight benchmarks to evaluate oral health access. If you haven't taken a look at where your state stands on the grade, I highly recommend it. These are the grades from our most recent report, *Making Coverage Matter*, which you can find on our website. But a lot of the folks in this room have effectively used these reports as policy levers to increase oral health access in your state.

Earlier this year Pew released a report on emergency room utilization for preventable dental conditions. We examined a large sample of emergency room data collected by a federal agency called the Agency for Health Care Research and Quality. We then projected the national number of emergency room visits by identifying the specific hospital codes for dental problems that are considered to be preventable. Unfortunately, this data is not available from all 50 states for two reasons.

First, not all 50 states collect or mandate that hospitals submit their discharge records. Also some states collect ER data, but they're not required to interpret it or report it. Here's an example of our overall findings. You also

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I believe have a copy of this in the packet, or it's on one of the tables. I highly recommend picking it up.

What we found was: preventable dental conditions were the primary diagnosis in more than 830,000 visits to the hospital emergency room nationwide in 2009. Children accounted for nearly 50,000 ER visits, and many of the visits were made by Medicaid enrollees or the uninsured. States are paying a high price for the significant number of children and adults who are seeking this type of care in the hospital emergency rooms. It could have been prevented and treated more effectively elsewhere.

What's really tragic about this scenario is that the kind of care that folks are receiving who go into the ER with a toothache is, it generally won't provide lasting relief. You traditionally don't have a dentist in the ER, and their response is to either subscribe a pain medication or antibiotic. This is not actually solving the problems. It's the wrong care at the wrong place at the wrong time for desperate patients. The more than 830,000 visits to the emergency room represent a 16-percent increase from this number in 2006. That's the bad news.

The good news is that there is a real opportunity for states to save money because these visits, again, are totally preventable. We know that getting treated in an emergency room

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is much more costly than the care delivered in a dental office, and states are bearing a significant share of these expenses through Medicaid and other public programs. I'll give you two examples. In Florida, dental related visits to the emergency room produce charges exceeding \$88 million in 2010. About one out of three emergency trips were paid by Medicaid.

In Washington State, dental problems were the leading reason for emergency room visits by people who were uninsured. Here are just more examples from the report that show that essentially tax payers and consumers are paying a high price for this incomplete care that's delivered in the emergency rooms. Why is this happening? Well, it boils down to access. The current system is not working for everyone.

This chart is taken from the American Dental Association. While it uses 2000 census data, it shows that roughly one third of Americans lack access to care, dental care, in the US. This is in line with what we're seeing from the 2010 census data. The logical next step is to look at the dental safety net. Well, the dental safety nets are at capacity. They are only able to treat 10 percent of this third of the population that's left out of the system.

Something else needs to happen. In addition, many people lack dental insurance. Even if that's not a problem for you, a lot of people have trouble finding a dentist. Many

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people have to drive 20 to 30 miles to access a dentist.

Currently more than 40 million Americans live in an area that has a shortage of dentists.

What can we do about it? As you heard from Dr. Hebl, there is no silver bullet when you're talking about increasing access to care. It's a pretty complicated situation that requires multiple solutions, but a lot of states are taking a look at evaluating the existing makeup of the dental workforce by talking about allied providers. Now I don't know how many of you guys are new to the dental world, but when I first started I thought allied providers was just one provider. It's actually a larger umbrella.

Dr. Hebl talked about the Community Dental Health Coordinator. Christy Jo Fogarty is going to talk a little bit about the dental therapy in the Advanced Dental Therapy in Minnesota. There are multiple models that we're talking about when we say allied providers, including the Dental Health Aide Therapist in Alaska and the Advanced Dental Hygiene Practitioner across the US. It begs the question, why are we having this conversation now?

Well, in addition to research showing that this is a viable solution to increasing access to care, we can't afford not to. While it's clear that states are bearing the consequence of folks not having adequate access to care, in

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certain circumstances the consequences can be much dire. A lot of people who are not new to the dental world are familiar with the tragedy of a Maryland boy, Diamonte Driver, in Maryland. This is continuing to happen in my home state of Ohio. We recently had a dad, an unemployed dad, who passed away at 27 because he did not have appropriate access to care.

This map is constantly changing, but it gives you an idea of which states are talking about workforce. The blue states show states that have authorized new providers: Alaska and Minnesota. The green states represent states where Pew is working, states where Kellogg is working, states where the American Dental Association is working, and states that have taken the initiative on their own. I commend them for doing this because it's not an easy conversation to have. I also appreciate the Alliance and Robert Wood Johnson Foundation for making this a focus of the briefing today.

If you'd like to keep up with the information of what we're doing at Pew Children's Dental Campaign, please feel free to sign up for our dental news and views. My colleague, Matt Jacob's information is right there. We're happy to share what we're doing monthly. Here's my contact information if you have additional questions after this briefing. Thank you.

EDWARD F. HOWARD, JD: Terrific. Thank you, Julie.

Finally we hear from Christy Jo Fogarty, who is as Julie

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described a licensed dental therapist; one of the first two people in the nation to receive this recognition. She started as a dental assistant and then became a licensed dental hygienist. Last year she finished two years of training as an advanced dental therapist and received a master's degree as an Oral Health Practitioner. She works for Children's Dental Services in Minneapolis. Some of you may have seen her featured in a recent PBS documentary on oral health. We're pleased to have you here to tell us about your experience. Christy?

CHRISTY JO FOGARTY, RDH, MSOHP: Well, thank you so much for having me here and allowing me to share the Minnesota story and what we're doing there, the real-life demonstration project that we have going on up there. I'm just going to cover a few topics rather briefly. I'm going to talk a little bit about the Advanced Dental Therapist and what we do, talk about our testing and training, tell you a little bit about where I work, the things that we do there, the demographics that I serve, and then a little bit about the financial model that we're starting to see develop as I now am there practicing.

I have been practicing for Children's for about a year. I'm also as was noted a licensed dental hygienist and a licensed dental therapist. Those two together, that dual licensure, really serves me well for this community. Then talk just a little about what's going on in the future and what

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we're looking at in Minnesota. I'll talk a little bit here briefly about what a dental therapist is; a midlevel practitioner.

The best comparison that's been made is much like a nurse practitioner but in dentistry. I can do just about any kind of fillings. I can do extractions of primary teeth, baby teeth. I can do stainless steel crowns. I can do pulpotomies, which is like a root canal, on a baby tooth. I can also do all kinds of space maintainers.

In Minnesota there are actually two types of therapists. There is the dental therapist and an advanced dental therapist. According to legislation, dental therapists are required to have a bachelor's, but many do have a master's. Currently the University of Minnesota is the only school that is teaching dental therapy. Advanced dental therapists are required by legislation to have a master's degree.

Currently, Metropolitan State University where I attended school is the only school that teaches advanced dental therapy. One of their prerequisites is that you are an experienced hygienist. When I applied to the program, I had to have worked at least 2000 hours, at least one year fulltime as a hygienist. I had 13 years of experience. I was probably right in the middle at the level of experience. The least amount of

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experience was six years, and we had one hygienist who had been a hygienist for 18 years.

After I complete 2000 hours, which is a lot like a residency, I will become an advanced dental therapist. The Minnesota Board of Dentistry currently is trying to figure out exactly what they're going to do to test me when I hit that number some time in about November of this year so that I can get that licensure. The biggest difference between the two is the supervision level. Dental therapists have to be in what we call in direct supervision. It means the dentist needs to be on the premises at all times while different types of procedures are being performed.

Once I become an advanced dental therapist I can do what's called general supervision. Meaning I can do everything within my scope of practice, but I can do it without a dentist needing to be on site with me. That's a huge advantage, especially when it comes to talking about working with mobile equipment in rural areas. You'll see later, there are some people who travel very far distances to come and see me and to get access to dental care. If I can get to them and not have to have a dentist in the same building as me, it's going to open up access to care significantly.

One thing I do always like to make sure people understand is it's my dual licensure that allows me to do a lot

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of things. By legislation, dental therapists and advanced dental therapists can't do a simple cleaning. They can't do any kind of [inaudible] work. I can do both, which really helps.

When you get this population into your chair, people are struggling to get access to dental care. You certainly want to do as much as you possibly can. It's not uncommon for me to do a stainless steel crown, a couple of fillings, clean their teeth, do sealants, and apply fluoride. For the training and the testing that we go through, I went through 27 months in a master's program, Metropolitan State. In my scope of practice, I'm trained to the level of a dentist.

I actually brought a code book here that talks about the 75 pages of codes that a dentist is licensed to do. Of those 75 pages, there are six that I can do as a dental therapist and an advanced dental therapist. There are three that I can do as a hygienist. If you can imagine, in 27 months for the exact scope of practice I do, I am trained excellent.

I am trained very highly the same levels as a dentist. I am trained by a dentist side by side with dentists. The testing that we're given is the same testing a dentist does. In fact, the testers do not know if it's a dental therapist or a dentist who's taking the clinical exam. After I have received licensure, I was able to get into a collaborative management

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practice agreement. Currently where I work I am in collaboration with nine separate dentists.

As I started out, there are different levels of supervision that they give me. By statute, they have to know what I'm doing and they have to be in the building. Some when they begin with me start by kind of seeing some of my prep, seeing some of my work. Most of them now just want to know what I'm doing.

A little bit about us: Last year we provided care to about 28,000 children. This year we're on track to do about 30,000. We work with mobile equipment you can see. Where at Head-Start-based programs at about 200 sites statewide, we're at about 300 sites. The vast majority of our care is actually not done at our headquarters, which is located in Northeast Minneapolis. The vast majority of our work is done on site in community centers, schools, and different types of permanent sites that we've established. You can see that we take anyone with any kind of insurance. We also have a sliding phase fee scale.

Basically we turn away no one. We see children under the age of 21, from birth to 21, and pregnant women. We also work a lot with children with special needs. I see a lot of children with autism, wheelchair bound; really the whole spectrum. We also at our headquarters can provide quiet rooms

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where we can decrease the stimuli and really help access those children who struggle not only to get care, once they get care they struggle to be cooperative with the care.

We also do have surgeons that—we also do have dentists who do surgeries in hospital care. Obviously I don't do that. We do have one dentist who comes in twice a month to do root canals for children. A little bit about the epidemics that I've served since December of 2011, I've seen about 900 patients. You can see the demographics there. I always like to just tell one little story because it kind of brings home exactly why I do what I do and why I believe so much we need to work on access to care.

When I first started doing dental therapy working in the clinic, a mom brought in a two-year-old little boy. You can imagine, with this sad, little face. He was in so much pain. The mom said he had not slept all night. He had fallen the week before. He bumped his front teeth. She had spent the entire morning calling around to dental offices being told again and again and again we don't take your public assistance insurance. We can't see you. We were her last call before she was going to take her son to the emergency room.

All of you guys had heard it's expensive, and it's not conclusive treatment. They would have given an antibiotic, some pain medication, and told the mother to find a dentist, which

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she had already tried to do all morning. She was tremendously grateful that our clinic was willing to see her son. Once we got him in the chair, I worked with my collaborative practice dentist. We determined that the tooth needed to be extracted. You can imagine that a two-year-old, not a non-traumatic experience. It was pretty awful for him, not to mention he hadn't slept and he was in pain.

You can imagine anyone who has a child how awful that situation is. The mother was so grateful we were able to get the tooth out for him, get him out of pain. Because I'm a hygienist, all I think of is preventive, preventive, preventive. I convinced the mother, please come back in next week. Get him in for a regular exam. Let's make sure there's nothing else that's going on now that we've got him out of pain.

A week later, I'm standing in the hallway and I see this little two-year-old boy come around the corner; ear-to-ear grin with a big missing tooth in the front. He takes off in as much of a sprint as a two-year-old can do, and he wraps himself around my leg. The mom comes up behind him and she says, "All he can remember is: You're the lady who took his pain away." This is why I do what I do. This is why I'm so passionate about it. The mother was grateful for care. The child needed the

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care. It could have gotten so awful for this child. Instead, he's on the right path to a good dental home. Excuse me.

Just a little bit about talk about the finances. This is a slide actually that one of the managers at our office was giving: A presentation to other dental clinics about kind of the business aspect to dental therapy. He put this slide up. One person raised their hand and said, okay. That's great. You save about \$12,000 a week having a dental therapist work in your office instead of a dentist. In collaboration it reduces the number of dentists we need to have in our office. It doesn't eliminate the need for a dentist, but that's great.

How do you get grant funding? How do you get funding to pay her salary? How do you afford her? He was a little confused by the question because he hadn't put this slide up yet. This slide shows that I produce more than the majority of the dentists in our office. There are two reasons for that: One, I work in a headquarters, which is very efficient; very busy all the time. Two, I have amazing collaborative dentists who really let me work hard and complete a lot of work.

I'm fortunate that because I'm not disturbed by an advanced dental therapist asking for my checks, or to be doing exams because I'm not quite licensed to do that yet. I won't be able to until I'm an advanced dental therapist. I can get quadrant dentistry done, which can be very challenging in this

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group. That helps a lot as well. My boss likes to say this is actually a really unfair slide because it shows that you're the third highest producer in the practice for the month of May.

The reality is you shouldn't even be compared to dentists because your scope of practice isn't the 75 pages that I talked about. It's six. Granted, they're probably the sixth most critical-six pages that are most critical of the procedures that need to be done by this population. It's a very important set of pages, but the dentist obviously would have an advantage in production because there are far more expensive procedures that they can do.

Now I just—we did pull out the month of May. This is not the only month that I've been the third highest producer. It is the highest I've ever been. I generally sit in third, fourth, or fifth every single month. My numbers do continue to rise. While I was the fifth highest producer in the month of July, my production did go up to \$320 an hour. The question that he got, he said really this: You don't need grant money. You just need to work them into your practice in the proper way.

For the future, I'm continuing to work working towards my 2000 hours. I expect to hit it November of this year. What Julie didn't mention in her slide that she showed, the grades that the states are getting, Minnesota has an A. Actually it

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was an A minus. Being the type of person I am, I'm really hoping once I become the first advanced dental therapist in the country that Pew will reconsider that grade.

The other question that I get a lot that I think is really important for people to know is: What's the acceptance been like? I thank God every day for nurse practitioners because it becomes very easy to explain what a midlevel practitioner is, what I do, and what I can be licensed to do. In one year of practice I've had one parent say I prefer my child see a dentist. The acceptance rate is extremely high. You have to remember, you're talking about a population that really needs dental care and is so grateful to have the care.

It's a very important message to get out there that this is one great tool. We're no silver bullet. There is no one silver bullet. You need a great big tool box to solve access to dental care. I think what I'm saying is, dental therapy is that great wrench you can use. Any time, that works. That's it. Thank you.

EDWARD F. HOWARD, JD: Perfect. Thanks very much, Christy. We get to this part of the program, and you get a chance to ask our panelists what you want to get out of this conversation. You have the opportunity to ask questions orally. You can take out the green card in your packets, write a question, hold it up; hold the card up. We'll bring it forward

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and give a chance for that person to respond to it and invite Dr. Krol to join in the questioning. I wonder if while we're getting started I could ask Dr. Hebl about the Give Kids A Smile program that you were talking about, the effort that you described in 2006 to focus on continuity of care and establishment of a dental home. How do you do that in a volunteer situation?

MONICA HEBL, DDS: Well, there are training—is that on?

EDWARD F. HOWARD, JD: You're on.

MONICA HEBL, DDS: —training opportunities and best practices so that programs that provide care on the one day, and found ways to get dentists to accept the patient's ongoing—who's a train the trainer kind of a thing. Dentists are pretty generous. If they build that relationship, a lot of dentists are willing to take those kids on once they get to know the families.

EDWARD F. HOWARD, JD: Okay, a question for Julie. I was looking at the map that you were displaying about the impact of emergency department visits. I wonder if there's much of a variation from state to state, among the states that you were able to get data for. You've got 800,000 of these visits a year out of a total number of visits of something like 140 million. Some of these percentages are just stunning in that context.

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JULIE STITZEL, MPA: Again, we were only able to¹I'm sorry. We were only able to gather data I think from 24 states. It's not all 50 states, but I think the general takeaway is that people are utilizing emergency rooms because they don't have access to care. It is an issue.

EDWARD F. HOWARD, JD: David?

DAVID M. KROL, MD, MPH, FAAP: A question for Dr. Mouden: With the Medicaid expansion coming, what are the efforts to broaden the provision of dental benefits, especially for adults? What do you see on the horizon?

LYNN MOUDEN, DDS, MPH: As we learned after the Supreme Court decision recently, we are still in the position where states can provide dental services for adults under Medicaid or not. That has not changed. Obviously we're still concerned that once they—an underserved area, a child has dental services until they turn 21. Now we just cut them loose. That doesn't mean that their dental problems or need for dental care have gone away. Unfortunately, we're still in the position where it's up to the states individually to decide whether or not they're going to provide adult dental services under Medicaid. With competing priorities in state budgets, it's going to continue to be a concern.

DAVID M. KROL, MD, MPH, FAAP: Have there been any discussions about dental benefits and Medicare?

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LYNN MOUDEN, DDS, MPH: In my office there have been those discussions. Unfortunately, as I get within a couple of years of that magic number—it's amazing that when people turn 65 in this country, we apparently no longer care about their oral health. I'm obviously being a little flippant about that, but the tremendous unmet need we have of seniors and their oral health is obviously a huge discussion for budget issues. I can only hope that maybe Medicare will catch up by the time I get there.

DAVID M. KROL, MD, MPH, FAAP: A question for Christy, and maybe even Julie. You can help out with this. Can you talk a little bit about the process that Minnesota went through to get this legislation passed?

JULIE STITZEL, MPA: Go ahead, Christy.

CHRISTY JO FOGARTY, RDH, MSOHP: The process actually—they say it's like making sausage. You don't really want to see it. You just want the end product. It was a lot like that. I fortunately had a lot of great advocates out there working really hard. I think the best thing that Minnesota did is: prior to going to the legislators and prior to presenting their case about why this was going to be such an important thing—you know because if you look at Julie's information, Minnesota was not the state by any means most in need of access to dental care.

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We created a huge coalition of people. One of the biggest advocates we had was a pediatrician who said if dentistry doesn't fix this, we're going to have to fix it because I'm seeing kids every single day with toothaches. We don't have any solutions. I think the best thing we did was creating this huge band of safety net coalitions, pediatricians, dentists, and a broad spectrum of people from a broad, broad background to come to the legislature and say we agree that this is something that we want to try. We want to expand the dental work force. This is how we want to do it, and we want your support.

JULIE STITZEL, MPA: But it was—it's not an easy, again, conversation to have because you have a lot of different perspectives coming to the table. It's important to take the time to understand where people are coming from, to respect where they're coming from and try your best to build some sort of consensus as you're moving forward. That it's not just the policy win, but you have an infrastructure in place to sustain that new policy. You have lasting change with respect to access.

CHRISTY JO FOGARTY, RDH, MSOHP: And I can vouch how little on setting that up. Way before the legislation was even presented Metropolitan state university already had an entire program approved by MnSCU in Minnesota. The education piece was

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already approved through the proper channels. As soon as the legislation was passed, I literally was sitting in a classroom three weeks before the legislation was signed. It was so ready to go.

EDWARD F. HOWARD, JD: Julie, if I can just follow up on the general topic of how you get states to act. You folks did the wonderful state by state evaluations of children's dental health policies. As I understand it, after the death of Diamonte Driver the state of Maryland really made major improvements. They don't show up on your map here with respect to dental therapists. What kinds of things did they do, and how did that happen?

JULIE STITZEL, MPA: Specifically with the state of Maryland, there might—actually I'd see Alice. She might be able to talk a little bit about what they did, but I'd say that they focused more on—let me just touch on our benchmarks. The eight benchmarks that we used to grade the states are—I'd say three are focused on prevention. One is focused on workforce. Another is on Medicaid or reimbursement rates. I'd say that Maryland tackled more of the prevention and the reimbursement rates on access. Not necessarily the workforce ones, but I'm sure others in the crowd might be able to add to that discussion. Yeah, okay.

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DAVID M. KROL, MD, MPH, FAAP: Just a followup on the number of student: How many students are enrolled in the Metropolitan State University program? What's the pipeline? How do things look going forward?

CHRISTY JO FOGARTY, RDH, MSOHP: Sure. The first cohort that I was in was seven. We are very small in numbers. The second cohort is about halfway through. They are four. My understanding from the University of Minnesota, and please don't quote me because I did not go to school there, their first class I believe was nine and their second class I believe is seven. We're looking somewhere in the 20 number range in the next 12 months. We'll be out there working in Minnesota.

DAVID M. KROL, MD, MPH, FAAP: Can they—other than Minnesota, can they practice in any other state? I guess including Alaska.

CHRISTY JO FOGARTY, RDH, MSOHP: No. We're not licensed—well, Minnesota is the only state that has dental therapy as part of state statute. It's actually a part of our Dental Practice Act. In Alaska it's a different situation. Probably there's someone on this panel who can speak more authoritatively than me, but I could not practice in Alaska. I cannot practice in any other state.

We have had several people move from other states to Minnesota, including one of the first in the cohort from the

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University of Minnesota who moved from Florida, because she was seeing such problems with access there, to Minnesota to become a part of the solution. Even though she could not go back to Florida, which I think is really what she would have loved to have done: To help in Florida. We can't practice in any other state right now.

EDWARD F. HOWARD, JD: I can do this. I've got a question. It sort of grows out of the presentations as we heard them, and it's directed to Dr. Hebl. What is the American Dental Association's take on advanced dental therapists like Christy? Are they in the ADA's view providing appropriate care at the appropriate level? How do you feel about Minnesota becoming a model for other states?

MONICA HEBL, DDS: I knew I was going to get this question. The ADA believes that with the scarce resources available to improve access to oral health, we believe a lot more can be done to fix the current delivery system. We have demonstration projects all over the United States. Healthy Kids Dental in Michigan is just one. I know Dr. Mouden knows about a few other successful programs. We really believe that the providers are there. We just need to fix the system around them.

We caution against a rush to create new work force models that are allowed to perform irreversible surgical

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procedures, especially about the scarce resources that could be directed toward dentists providing the care. It seems a little upside down to me to be having—the sickest people should be treated by the highest trained. I don't think that treating a two-year-old with a dental abscess is a simple extraction.

In fact in preparation for this event, it just seems like I have been inundated with some really difficult extractions; primary teeth. Hardest extraction I've had in the last two weeks, a gentleman that came in with softball-sized swelling. A woman who I took a tooth out that I thought was going to be a simple extraction and had a bleeding emergency.

I was—I think that that's—we'd like to see dentists be involved in the cutting of hard and soft tissue. We think it can happen with a better system. All of us working together to make that happen instead of diluting the message and having it be on this divisive issue of workforce.

EDWARD F. HOWARD, JD: Do we need more dentists as well?

MONICA HEBL, DDS: Well, there are 20 new schools in the pipeline. When you look at Christy's training, that's about six years of training. Dental school is eight. I just think that it takes a long time. I don't know that that necessarily is going to be an immediate help, and we need the help now. We should find ways to make it so that we can involve all the

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people that are already members of the team and use them to their fullest capacity.

We have hygienists who can't find jobs and aren't used. We have dentists who aren't busy right now. It's an economic issue. When you work in a subsidized system, you can make things happen. We need to try and figure out how we can make the health care dollar for oral health work in the system that exists.

EDWARD F. HOWARD, JD: Yes. We have some folks who are standing at the microphones. We would ask them to keep their questions as brief as they possibly can and to identify themselves.

BOB GRISS: Bob Griss with the Institute of Social Medicine and Community Health. I was—I think Dr. Moudan mentioned that Medicaid pays maybe 20 percent of the private pay rate.

LYNN MOUDEN, DDS, MPH: Let me stop you right there because I was speaking from my personal experience practicing in Missouri almost 20 years ago. That's not national data by any means.

MR. GRISS: Alright. My question is: How could Medicaid as a federal agency allow states to pay so much less than the private insurance market or the private pay market bears? The Medicaid statute says that the Medicaid program is supposed to

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ensure equal access, and that usually means paying a rate comparable to private pay. I'm surprised that states are allowed to pay less, but I'm also curious what percentage of dentists choose not to take Medicaid patients and why that is allowed also as a licensing issue. In other words, shouldn't states use their licensing authority to ensure that dentists are making their services available to the population within their area?

LYNN MOUDEN, DDS, MPH: I'll give those both a try because what you've actually asked about are two state issues. There is something called sufficiency in the Medicaid program where access is to be basically equal to what's available in the private market. Again, that's a state issue, which is totally dependent on budget.

The second thing you ask about is licensing, very much a state issue. Whether any health care provider—be it dentist, physician, nurse, or otherwise—is required to take public assistance programs is a discussion that I don't think I'm allowed to have.

EDWARD F. HOWARD, JD: Don't feel constrained if you'd like to weigh in. Anyone else? Yes, go ahead.

KATHIE WESTPHELING, MPH: Do I get to speak? Hi, I'm Kathie Westpheling, Executive Director of the Association of Clinicians for the Underserved. First, thank you for a very

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informative panel. It's nice. David Krol and I have worked on this issue of oral health for a number of years. It was the first topic that we actually brought together, people across the disciplines, to look at early childhood caries prevention. My question is addressed to Christy. What is the cost of the preparation for your advanced dental therapist, and what are the opportunities for state or federal loan repayment in the future?

CHRISTY JO FOGARTY, RDH, MSOHP: That's actually a really good question, and one that—a little bit of a struggle in Minnesota. The answer to the first question is: education to become an advanced dental therapist. Now remember, the program that I went to required that I already have a bachelor's in dental hygiene. When we were talking about six years of education versus eight, we do have an educated hygiene workforce right now that could step in and 27 months be out producing and doing work. It's not another six years. I just want to clarify that.

Just the dental therapy program at Metropolitan State is about \$70,000. I know that a dentist that I work with, when she came out of dental school she was about \$350,000 in debt. It's not—we are among the most expensive professionals to be trained: Dentists, hygienists, and therapists. It's an expensive process to train us.

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The second answer to the question is: I was able to apply for some loan forgiveness. However, it's a national program. I qualified because I'm a licensed hygienist. Dental therapists are not right now eligible for the program. Unless you're going through a program that starts in a foundation of hygiene, you won't be eligible for any loan repayments statewide or nationally right now.

EDWARD F. HOWARD, JD: Do we know anything about the total cost of the program as opposed to the costs that the students are asked to bear? In either case, whether we're talking about dentists or any of the other professionals.

CHRISTY JO FOGARTY, RDH, MSOHP: I do not have those numbers, but I can get them.

EDWARD F. HOWARD, JD: Do you have any idea? If we can get those, we'll make sure we post them on our website. Yes.

COKIE SMITH: Hi, my name's Cokie Smith. I'm a reporter for Youth Today. My question is rather basic, and I apologize if people mostly know the answer. I'd like to know: Why is there a shortage of dentists in the country? What are the factors affecting that? Why is the answer getting more dental therapists for example? Why not recruit more people to become dentists?

EDWARD F. HOWARD, JD: Dr. Hebl, you want to start?

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MONICA HEBL, DDS: Actually there is a maldistribution of dentists. The rural areas and the urban areas, there aren't enough dentists because you can't economically sustain a practice in those areas. We need to find ways with loan forgiveness and incentives to get dentists to be able to practice there so they can sustain. We just had a pediatric dentist that had to sell his practice to a hospital system because he couldn't compete. He's not a federally qualified health center. He doesn't get the subsidization from the government. He couldn't keep dentists employed. They would leave and go somewhere else.

I think that that's where I was talking about. The system that we have with 20 new dental schools opening, we have the capacity. Baby boomers aren't retiring like they were before the economy downturned. There are professionals. There are hygienists that are already on the ground that we could expand the scope of what they do and utilize them to their full effect; even dental assistants. We think the capacity is there. It's just where they're located is the problem.

EDWARD F. HOWARD, JD: Julie?

JULIE STITZEL, MPA: Yes. Also, I'd reiterate a stat that I used in my presentation, that 40 million Americans currently live in an area where they don't have access to a dentist. The research shows that, well, that is the fact. The

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reason why we believe that dental therapy is a possible solution is because it does make economic sense. Pew released a report in 2010 that produced an economic model that showed that adding this dental therapy, as Christy Jo's real data backs up— I mean at the time it was a theoretic economic model, but Christy Jo is living proof that this actually does—it does not affect the bottom line of the private practice.

Our model focused on private practice. That's one of the reasons why we're in it. Our overall reason is because we believe it increases access to care, and a third of our population is currently left out of the system.

KAREN S. SEALANDER, JD: Hi, I'm Karen Sealander with McDermott Will & Emery. We represent the American Dental Hygienist Association. Thanks so much to the Alliance for holding this briefing. I just wanted to respond to something that Dr. Hebl said that seemed to call into question the safety and efficacy of irreversible procedures provided by advanced dental therapists like Christy.

While it may be new in the United States, more than 50 other countries for nearly a century have used non-dentists to deliver these so-called irreversible procedures. Every single study demonstrates that they can safely and effectively provide these services. There's rigorous research that absolutely demonstrates that non-dentists can deliver safely and

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effectively irreversible procedures. I just—I've never seen a study that shows anything contrary. I don't know if Dr. Hebl has some studies to share with us, but—

MONICA HEBL, DDS: I guess my response would be that whether we have Christy Jo out there or you have Dr. Monica Hebl or you know anybody; unless we get people navigated to those places and teach them that they need to access ongoing prevention to stay healthy—that they need to brush and floss their own teeth—it doesn't—it almost doesn't matter who's out there.

KAREN S. SEALANDER, JD: Well, I completely agree that oral health literacy really, really needs to be improved. I think that advanced dental therapists like Christy Jo, any hygienist; I think they really do know when a patient needs to be referred to a dentist. I don't think anybody wants to supplant the dentist. But because there aren't enough dentists, I think we need to supplement the care that's provided by dentists.

EDWARD F. HOWARD, JD: Thank you.

KAREN S. SEALANDER, JD: Thank you.

FEMALE SPEAKER 1: First of all, thank you very, very much Robert Wood Johnson for organizing the session, Dr. Krol, and for all of the speakers. I'd like to change the direction of the discussion just a little bit. What my perception of what

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we're talking about is who gets to hold the drill to fill the holes that we could have prevented. I think this is really so unfortunate.

We know, and this has been stated by at least three of the speakers, we know how to prevent tooth decay. That is basically the disease we're talking about. When fluorides are used appropriately and pit and fissure sealants, we can prevent caries for the most part tooth decay. Yet we're focusing on who's going to hold the drill. Why aren't we sharing more information about, to the general public, especially low-income?

People with low health literacy, they don't even know that this disease can be prevented. We have data in Maryland that demonstrated clearly that low-income, low-educated don't know what fluoride is, how it works, that it prevents tooth decay; never heard of pit and fissure sealants. Fluoride has been around and used for almost 75 years, pit and fissure sealants for about four decades. Yet we haven't shared that information?

It seems to me where we should put focus is on trying to educate both health care providers because they don't necessarily know the correct information either as well as the general public. Which brings to mind a question for Dr. Hebl: On your slide, one slide what it said what the new campaign is

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about. I think ADA put in several million into that as I recall. It says toothbrushing two times a day for two minutes to prevent tooth decay.

Now there is no evidence that brushing two times a day for two minutes will prevent tooth decay. You have to put fluoride on the tooth brush, and yet that word isn't even used in any of the documents that are online. Not online, but are available to the general public. This would be a major step ahead if you even used that word. Thank you.

EDWARD F. HOWARD, JD: Sure.

MONICA HEBL, DDS: The ADA was part of that huge coalition. The group that does that ad council really does a lot of research in focus groups. We kind of had to take a step back a little bit and take off our hats of wanting to try and control that message and trust them that they knew what they were doing in the marketing world; that this was through their focus group research that this was an appropriate message to get at what you're talking about. I agree that it seems like, is this going to work?

A big part of this campaign is to measure the results. If it doesn't get results, it won't continue to happen. It could be tweaked. The group, the marketing firm that does this is the same one that did the messages of the little baby in the crib for E*TRADE. They usually do really put out some effective

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campaign. I'm hopeful that this is the first step and that we can get to the point that you're talking about. Yes.

EDWARD F. HOWARD, JD: A couple of people now have talked about prevention, both fluoridation and the sealants. Where is that in a national policy sense? Is it covered by any of the Medicaid programs? Do the private insurance companies that we all rely on for the most part cover that service? Where is there some opportunity for progress?

LYNN MOUDEN, DDS, MPH: Well, I'll jump in. For starters, obviously Medicaid is very supportive of dental sealant programs, which is why application of at least one dental sealant is one of our oral health goals. We also obviously in states cover the provision of fluoride treatments including fluoride varnish and including fluoride varnish provided by non-dentists, by physicians and nurses especially on toddlers.

Whether there is a national program on community water fluoridation, that we leave up to our colleagues at the CDC division of oral health, which has provided a considerable amount of funding to various state programs to support water fluoridation. I'm always very thankful to some of the private foundations that have also helped support community water fluoridation across the country.

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JULIE STITZEL, MPA: At Pew we've—that's one of our areas of focus because we know that 74 million folks on the private water system do not have access to community water fluoridation. We are working to create a sort of national home base with the website I like, myteeth.org I believe. I always get the org or the com mixed up. I like myteeth.org. That provides a toolkit for folks who are interested in fighting either roll-back attempts or increasing fluoridation in their water.

It's a tricky topic because the antis are somewhat effective in planting a fear factor, which you have to then combat with science. You tend to lose people that way. Finding the right balance of communicating education but also providing tactics so that people can effectively keep their water fluoridated or get their water fluoridated is a challenge.

EDWARD F. HOWARD, JD: How about the—

FEMALE SPEAKER 1: Could I just add on that? I'm over here. I jump around. I recognize what you're saying, and I agree with that. Here's a major problem. With all the bottled water that's available, including in here, most people are not drinking tap water. A large part of it is because they don't know that fluoride's in it and it's good for them. It seems to me we need major educational campaign about water fluoridation and get it from the tap. It doesn't do any good to have tap

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water in community water fluoridation if it's not being consumed. You got to drink it. You can't just wash the car with it.

EDWARD F. HOWARD, JD: You have anything there that you'd like to get to?

MALE SPEAKER 1: Dr. Mouden mentioned the focus on issues at a state level. Is there a national oral health plan or a national strategy for oral health? Are there opportunities for coalitions like the US National Oral Health Alliance or other organizations to help push a national oral health agenda?

LYNN MOUDEN, DDS, MPH: Well, I'll jump right in. The Oral Health Coordinating Committee, again made up of the dental representatives from various federal agencies, is in discussion now about what could be called a plan. We tend to not use that word because there have been too many plans. Whether it's called a strategy or whatever, getting the different federal agencies to work together in a combined effort to improve oral health and access to oral health care.

Beyond that of course we've had the Healthy People goals now in our—what are we now in, our fourth iteration of Healthy People plans? We continue to see oral health as a major focus in healthy people, now Healthy People 2020. We would obviously want everybody that is represented in this room and anybody else watching to take those seriously. They're not just

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pie in the sky. There are things that seriously can be done through various partnerships; federal, state, and local.

EDWARD F. HOWARD, JD: Yes. We have a repeat offender here.

COKIE SMITH: I'm Cokie Smith from Youth Today again. I just had a couple of follow-up questions just based on I guess my previous question on why dental care is not readily available in certain low-income areas. I guess the question is then: Does that mean that dental care is too expensive for most people? Then the question is why. Because if we do have more dental therapists for example as part of the solution, from what I understand they can only address a few of the procedures, not the full spectrum of dental care.

If there is a low-income person who needs more advanced care, that's still going to be very expensive. Who then pays for that? How do they still get access to that more advanced care? I guess connected to that is the second question: What is the Affordable Care Act doing to address dental care? Can you speak to that?

What kind of larger solution is there for low-income people to have access to the full range of dental services? Not just the small piece that dental therapists can provide. I understand that's an important part, but I'm just trying to get

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the bigger picture. What is the bigger picture? Who do we get care to everybody, the full spectrum of care?

LYNN MOUDEN, DDS, MPH: Well, I'll take a small piece of that. Under the Affordable Care Act we have what are called essential health benefits that will be covered under the various insurance entities. Whether it's the exchanges or private pay insurance, it will be a basic package that does include dental benefits.

MONICA HEBL, DDS: I'll take another small stab at it. I think that's why prevention is so important, because this is a disease that doesn't have to happen. While there are people out there that need some expensive care, if we can change the perceptions, the home care, the attitudes, and get people to go for preventive visits and ongoing care, we can get them healthy so their oral health care costs are much less.

Then dentistry has always been an industry where there are out-of-pocket costs. It's been treated kind of as a discretionary income kind of thing. That's why this downturn in the economy has been so tough on private practice, because people can put off going to the dentist, going to the eye doctor. The advantage of that is that there is transparency in the costs of oral health care, as opposed to medicine where there isn't a lot of transparency. That's an advantage and one

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thing that we don't think is being translated to the medical world as well.

It's a complicated issue. Again, that's why so many people need to put their heads together to figure out how we're going to do this, how we're going to fund it fairly and effectively and make sure that the most appropriate person is treating the most appropriate patient.

JULIE STITZEL, MPA: One more thing about the Affordable Care Act, it appropriates 11—I think what is it—\$11 billion for community health centers over a five-year period. That's something specific that the Affordable Care Act does.

EDWARD F. HOWARD, JD: Now the demonstrations that Dr. Mouden was talking about are included in the ACA, but they're subject to appropriations as I understand it.

JULIE STITZEL, MPA: Mm-hmm.

LYNN MOUDEN, DDS, MPH: That's correct; authorized but not yet appropriated.

EDWARD F. HOWARD, JD: By the way, we're getting toward the end of our time with you. I would ask that as you listen to the exchanges, questions, and answers that you pull out the green evaluation form, make that the blue evaluation form and fill it out so that we can try to respond to the kinds of topics and the kinds of speakers and the kinds of formats that you'd like to see in these briefings.

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MALE SPEAKER 2: Can someone explain the difference between the dental therapists—the different types of dental therapists which are limited to a state; but expanded-function dental assistants who seem to have some similar work scope but are widely used and accepted by dentists and dental organizations?

CHRISTY JO FOGARTY, RDH, MSOHP: I can probably take a little bit of a stab at that. Nationwide dental assistants, dental hygienists have different scopes of practice. Every state has their own dental practice act. They can allow certain types of procedures to be done. For example, prior to being a dental therapist I was what's called a restorative expanded functions dental hygienist. Assistants can do this as well in the state of Minnesota, where a dentist could go in, prep the tooth for a filling, and that I could come in and do the filling.

What that does is, it allows the dental team to work more efficiently, see more patients, and hopefully open up access to get dental care. That's what it was designed for in Minnesota. Now there are those types of allowances in lots of different states. Not all states allow it. Not all states require licensure. Another thing that I also am is; I'm a collaborative practice dental hygienist in addition to be a

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dental therapist, which means there are times I still actually just work as a hygienist.

I may go into a school, and I can place dental sealants without a dentist present. I can do a cleaning. I can do all kinds of evaluation. I can do X-rays, things of that nature. Those are all under that collaborative practice agreement. That's allowed in the state of Minnesota for dental hygienists to do. That's what they're talking about. It varies from state to state, which is actually a very appropriate way to do it because the state is best at knowing what its needs are.

EDWARD F. HOWARD, JD: Yes, Monica?

MONICA HEBL, DDS: Just basically the difference is the cutting of hard and soft tissue. A dental therapist can cut the tooth and do the surgical part of it. An advanced dental assistant just restores it and doesn't cut the prep.

EDWARD F. HOWARD, JD: I want to come back to the question of rates and compensation. There are a couple of questions that arose. One is for Christy Jo. Looking at the slide that you displayed showing you the third ranking producer in that practice, what's the mix of pairs? Are there any private insurance numbers in that list?

CHRISTY JO FOGARTY, RDH, MSOHP: We do have a small amount of private pay patients. There are some patients who just really enjoy our clinic because it's a great environment

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for kids. It's a close location to where they live. We also have, I wouldn't say a large number, but a number of people who kind of move in and out of the public system and private system depending on employment and things like that. The vast majority of the patients that I see are on some type of public assistance program or sliding fee scale. We go all the way down to zero as patient responsibility depending on what their income is.

EDWARD F. HOWARD, JD: What percentage—that's probably too precise a question. How able are you to respond to the level of need for folks in vulnerable populations, either without any coverage at all or coverage through Medicaid?

CHRISTY JO FOGARTY, RDH, MSOHP: You mean in my scope of practice?

EDWARD F. HOWARD, JD: No. I mean in terms of the number of Minnesotans who are in need of those kinds of services.

CHRISTY JO FOGARTY, RDH, MSOHP: I probably couldn't give you a percentage, but what I can tell is like I said before: We have 300 off sites. We go all over Minnesota. I've been 60 miles south of my home working in a school for the deaf and the blind. We have people who go all the way up on the Iron Range. If you don't know how Minnesota lays out, that's probably about 500 miles from our home. Where we can go up, go

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into a community for three or four days, do the exams, do treatment, do cleanings.

It's not ideal. It's not a dental home, but we try to be consistent in getting there at least once a year so the people who don't have access in that community have something. It's more of a safety net, but we do have permanent dental homes in Duluth and in St. Cloud. We've got one spot in Northern Minnesota, one part of Central Minnesota, and of course the twin cities are in the southern part of the state. Does that help answer your question a little bit?

EDWARD F. HOWARD, JD: Yes, it does.

CHRISTY JO FOGARTY, RDH, MSOHP: Yes. We try and go to the people because one of the biggest obstacles to accessing dental care is quite often getting to the dentist. We try to go to them.

EDWARD F. HOWARD, JD: We know that somewhere there are 47 million people who aren't served by your kind of an agency or any other.

CHRISTY JO FOGARTY, RDH, MSOHP: Correct.

EDWARD F. HOWARD, JD: What about the National Health Service Corps and the federal resources that flow from it? I suppose this is more a HRSA question than it is a CMS question, but you must do some—you mentioned your connection with your colleagues at HRSA.

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LYNN MOUDEN, DDS, MPH: I apparently said too much. I frankly know very little about the National Health Service Corps. I do know that those scholarships are available. There is loan repayment available to those practitioners going into underserved areas, health professional shortage areas. I also know that there are literally hundreds of National Health Service Corps sites still looking for oral health providers.

EDWARD F. HOWARD, JD: Monica?

MONICA HEBL, DDS: Actually that vacancy number is much lower than it was before the economic downturn. Amazing what a recession will do for those kinds of programs in getting people involved. One of the things that happens with that program is, you don't find out if you get that loan forgiveness until after the fact because they kind of put it in the hopper and shuffle it around and then spit out the loan forgiveness.

Then also if you take the amount of the loan forgiveness and you would have a dentist providing the services—if you took the write-off for the Medicaid program, it's basically a wash. We always say in Wisconsin, we need meaningful loan forgiveness programs to make a difference.

EDWARD F. HOWARD, JD: Well, I think what we have demonstrated today if nothing else is that this is a multifaceted area of inquiry. Opportunities and challenges abound. I think what you've heard today is a rich description

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of both the challenges and some potential options for dealing with those challenges. I want to thank our colleagues at the Robert Wood Johnson Foundation, particularly Dr. Krol for allowing us to get into a topic we don't get into often enough. You are absolutely right.

I want to thank you for showing up on a beautiful August day and sticking with this discussion. I want to ask you to join me in thanking our panel for an incredibly useful and basic discussion of a very complicated topic. You can take the rest of August off from the Alliance.

[END RECORDING]

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