ADA American Dental Association®

America's leading advocate for oral health

Breaking Down Barriers to Oral Health for All Americans:

Repairing the Tattered Safety Net

A Statement from the American Dental Association

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ADA series on

Access to Oral Health

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As the nation's economy continues to struggle, increasing numbers of Americans find themselves unable to pay for dental care, whether indirectly through their individual or employer sponsored insurance, or directly out of pocket. Many also lack other resources to access care even when it may be available to them. For this growing population, the so-called oral health safety net is the only recourse for preventing and treating oral disease.

Prefacing the term safety net with the qualifier "so-called" is a key to fully understanding its weaknesses. While details differ within the public health community, the general definition of safety net is the sum of the individuals, organizations, public and private agencies and programs involved in delivering oral health services to people who, for reasons of poverty, culture, language, health status, geography or education, are unable to secure those services on their own. But the sum of these entities does not constitute a whole. Referring to them collectively facilitates discussion, but they cannot realistically be called a system, nor referred to as an effective safety net.

In too many cases, patients' urgent need for treatment of acute dental disease is what propels them to seek care in the safety net. Treating disease that could have been easily prevented or treated in its early stages, but has progressed to the point of chronic infection, lost gum tissue and bone, and inevitable removal, is one of the major reasons why these clinical delivery systems remain overwhelmed.

We approach this topic with the acknowledgment that the vast resources needed to evolve the safety net into a true system of care for the millions of Americans in need are unlikely to materialize in the current economic climate. However, significant reforms are possible, and the tattered safety net can be repaired and enhanced in ways that cost little and that could extend good oral health to many more underserved and neglected individuals and communities.

Although critical of the weaknesses of many oral health safety net components, this paper should not be perceived as criticizing the thousands of dentists, allied health professionals, or public and private sector workers and volunteers who constitute the backbone of the oral health safety net. To the contrary, its sole purpose is to serve as another expression of the ADA's commitment to supporting them and their tireless efforts through education, advocacy and action.

With the acknowledgment that change to the current system is necessary and is a process and not an event, the ADA is determined to lead what must be the concerted efforts of not only the dental profession, but also governments at all levels, the private and charitable sectors, and all Americans with the will and desire to achieve the goal of a healthier, more productive nation. If all of the stakeholders involved keep that goal at the forefront of our thinking and actions, we can truly progress toward better oral health for all Americans.

Raymond Gist, DDS

Raymond F. Gist, D.D.S.
President
American Dental Association

Breaking Down Barriers to Oral Health for All Americans: Repairing the Tattered Safety Net

Safety Net Components

In a 2006 article published in the *Journal of the American Dental Association*, Howard Bailit, D.D.S., and colleagues wrote, "The underserved population consists of 82 million people from low-income families. Only 27.8 percent of this population visits a dentist each year. The primary components of the safety net are dental clinics in community health centers, hospitals, public schools and dental schools. This system has the capacity to care for about 7 to 8 million people annually. The politically feasible options for expanding the system include increasing the number of community clinics and their efficiency, requiring dental school graduates to receive one year of residency training, and requiring senior dental students and residents to work 60 days in community clinics and practices. This could increase the capacity of the system to treat about 10 million people annually."

Bailit et al acknowledge that even such an increase in capacity would fall far short of meeting the needs of the vast majority of underserved patients who would still lack a source of care, writing, "The majority of low-income patients would need to obtain care in private practices to reduce access disparities." They further concluded, "The biggest challenge is convincing the American people to provide the funds needed to care for the poor in safety net clinics and private practices."

The private practice community is a major safety net component that is not part of the public health system but that accounts for the greatest proportion of hands-on care delivered to underserved populations. Any serious effort to increase the amount of care available to the underserved in any meaningful way must better incorporate the approximately 170,000 privately practicing dentists who represent some 91 percent of the nation's professionally active dentists.

Safety Net "System"

Clinical Services	• Charity and volunteer programs • Dental schools • Federally Qualified Health Centers • Free clinics • Hospital emergency departments • Indian Health Service and tribal clinics • Local health departments • Long-term care and special needs services • Non-dental providers (i.e., physicians, and school nurses) • Private practice (Medicaid, CHIP, in-office pro bono care) • Residency programs in hospitals, clinics and dental schools • School-based programs
Non-Clinical Support Services	• Federal Oral Health Programs (Head Start, WIC, HRSA workforce grants) • Social services (case management and patient navigation) • State Medicaid and CHIP • State Oral Health Programs

Clinical Safety Net Components

Grant-Supported Federally Qualified Health Centers (FQHCs) are non-profit health care organizations that are partially funded by grants from the Health Resources and Services Administration (HRSA), an agency of the Department of Health and Human Services. In order to qualify for this status, these health centers must provide comprehensive care that addresses the major health needs of the target population and must ensure the availability and accessibility of essential primary and preventive health services, including oral health services. Some health centers receive additional funding through HRSA's Ryan White HIV/AIDS Program. Others receive funding through the agency's Healthy Start Program to provide services to high-risk pregnant women, infants, and mothers in communities with high rates of infant mortality.

In 2009, HRSA-supported health centers treated nearly 19 million people. Forty percent had no health insurance; one-third was children and approximately two-thirds were members of minority groups. Some 3.5 million people received dental care during approximately 8.4 million visits.

Recognizing that barriers to care go beyond difficulties in obtaining clinical services, many health centers also provide non-clinical services to help patients adopt healthy behaviors and receive available care when they need it. These include translation or interpretation, case management, community outreach and nutrition counseling. Some health centers provide care in such non-traditional sites as schools, homeless shelters, public housing, migrant camps, and through mobile medical or dental units.

The vast majority of the total 1,131 FQHCs operating in 2009 provided some dental services. (Note that the term FQHC applies to organizational health care systems, rather than individual facilities. Many FQHCs operate multiple sites, and there were more than 8,000 sites in 2009.)

Among the requirements to qualify as an FQHC, a health center must:

- Be located in or serve a high-need community (designated Medically Underserved Area or Population) or specific high-risk target population.
- Be governed by a community board composed of a majority of health center patients who represent the population served.
- Provide comprehensive primary health care services as well as non-clinical services that promote access to health care.
- Provide services available to all, with a sliding fee scale based on ability to pay (family size and income) for those individuals living at 200 percent or below of the

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federal poverty level (FPL, currently $22,350 for a family of four in the 48 contiguous states). Patients living at greater than 200 percent of the FPL pay full fees, which are set by the health center to align with the area's average fees.

- Meet other performance and accountability requirements regarding administrative, clinical and financial operations.

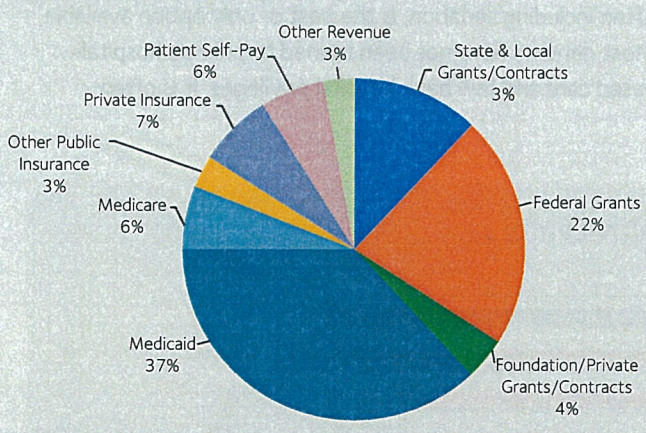
FHQC Dental Services:

- 934 (82.6%) FQHCs provide restorative services
- 911 (80.5%) provide emergency services
- 1,119 (98.9%) provide preventive services

FQHCs often refer patients to private practice general or specialist dentists, many of who provide care for free or at discounted rates.

In 2009, total federal funding of health centers was $2.51 billion, or 21.8 percent of total health center revenue ($11.5 billion).

Funding Sources for Federally Qualified Health Centers



Source: National Association of Community Health Centers, Inc.

HRSA has earned a well-deserved reputation for infrastructure building, a reputation now threatened by the combination of an increasingly crumbling federal oral health structure and the unprecedented growth of oral health programs within health centers. HRSA last issued oral health guidance to health centers in March 1987.

In the absence of the leadership and technical assistance that the agency once provided, guiding and mentoring the increasing number of new health center dental directors has fallen largely to FQHC executive directors and fiscal officers. These well-meaning administrators cannot provide the expertise needed to foster sustainable and efficient dental programs. This lack of direction is evident in the growing number of dental programs facing sustainability issues. Some health centers allocate federal grant dollars solely to medical programs, expecting dental programs to be self-sustaining. Some resort to "churning," in which patients undergo single procedures over multiple visits, rather than multiple procedures in a single visit, in order to increase revenue. This activity raises ethical concerns and adds to the barriers patients must overcome to receive care.

Federally Qualified Health Center "Lookalikes" meet the federal definition of "health center." They do not yet receive federal grant funding but are in the process of applying for it. There currently are about 100 of them.

Local Health Departments

Local public health agencies (LPHAs) can provide a tremendous amount of dental care to children. But according to the National Association of County and City Health Officials, only 22 percent (about 660) of the nearly 3,000 U.S. LPHAs include oral health programs. This is yet another manifestation of a pervasive societal failure to understand and value oral health. Historically, public health programs and oral health programs have not been well integrated, and funding for oral health services is disproportionately small when compared to the great need. With state and community support, local health departments can be effective safety net components.

- In Tennessee, local health departments in 53 of 89 rural counties and all six metropolitan regions include dental facilities.
- In Florida, 49 out of 67 counties provide primary care dental services, largely to Medicaid enrolled children.
- In North Carolina, 79 percent of counties have state-funded preventive dental programs and 9 percent have locally funded preventive programs.

Unfortunately, these examples may be waning. Several major cities (including Chicago and New York) and counties (includ-

ing Cook, Ill. and Snohomish, Wash.) have in recent years cut back or entirely eliminated their oral health programs owing to budgetary constraints. This illustrates starkly how relying on a single system of care for low-income and other underserved populations can wreak devastating damage on oral health programs.

School-Based Health Centers and Sealant Programs

School-based health centers are a proven, effective component of the nation's health care safety net. They not only enable children with acute or chronic illnesses to attend school, they also improve the overall health and wellness of all children through screenings, health promotion and disease prevention activities. During the 2009-2010 school year, there were only 1,909 actual health centers connected with U.S. schools, representing a tiny fraction of the 98,817 public schools operating that year.

Schools, especially those that serve low-income families or are in dentally underserved areas, are an obvious place to provide proven, low-cost preventive services to those children at greatest risk for dental disease. More than half of school-based health centers screen children for dental problems. A smaller number of these centers offer dental care and sealants.

Studies have shown that school-based sealant programs have reduced the incidence of dental decay by 60 percent. Children aged 6 to 17 years whose family incomes are less than the federal poverty threshold are twice as likely to develop cavities in their permanent teeth as are children from families with greater incomes. But only about 20 percent of children aged 6 through 11 from low-income families has received sealants, as compared with 40 percent of children from families with incomes greater than two times the FPL.

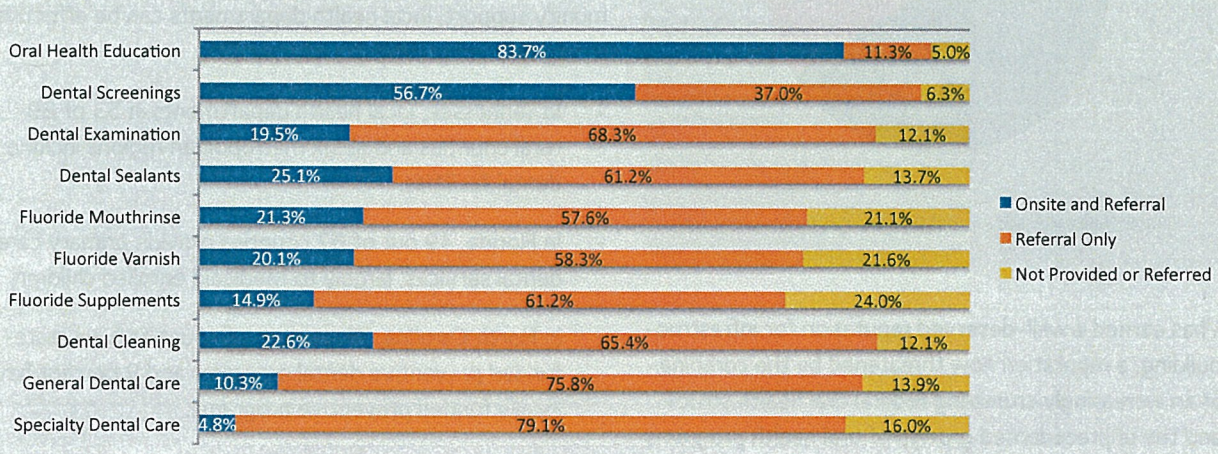
The number of children receiving sealants through school-based programs has increased significantly in recent years, and the positive results clearly indicate the need to expand these programs. Increasing numbers of programs also offer fluoride varnish, another inexpensive, proven treatment to prevent dental caries.

Long-term Care and Special Needs Populations

Budget cuts also have hit oral health care services for people living with disabilities especially hard. Delivering care to institutionalized and other special needs populations experiencing multiple health complications often layers complex logistical issues onto what already are difficult clinical situations.

Some disabled patients cannot safely receive care in conventional dental offices. In these cases, treatment in hospitals, often including sedation, is the best or only option available. Most dentists have not been trained to provide hospital-based care and few have hospital privileges. It is often

Dental Services Offered by School-Based Health Centers



Source: National Assembly on School-Based Health Care, 2009

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difficult for patients who need to be treated under general anesthesia to find a dentist. And Medicaid or some private insurers often balk at paying the costs associated with hospital dental care. These issues can delay care and allow disease to progress, leading to pain or infection.

Responding to this need, **Grandview Medical Center**, in Dayton, Ohio, created a hospital-based special needs dental program and employed a full-time dentist to treat patients under general anesthesia. The facility treats as many as 500 patients a year. The program has been operating since 2001 and is self-sustaining with costs offset by revenue from dental services and operating room charges.

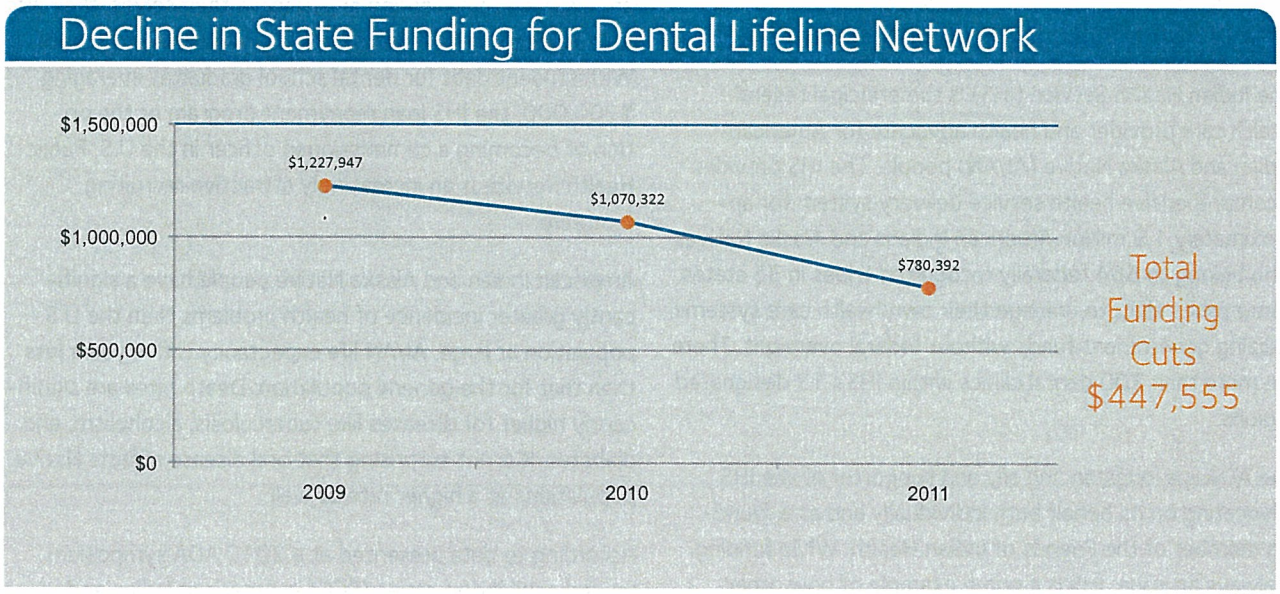
The **Tufts Dental Facilities Serving Persons with Special Needs** program operates eight dental clinics across Massachusetts that serve people with mental retardation and developmental disabilities. The program includes prevention-oriented outreach to 200 communities, a hospital-based component that provides care in operating rooms, and an educational component that trains dental students and general practice residents. Six of the clinics are on the grounds of state institutions, but all of the sites are available to people living in the surrounding communities. The program has had an enormous impact on increasing access to dental care for people with disabilities whose needs largely exceed the private sector's capacities.

The **Dental Lifeline Network** (DLN) coordinates the Donated Dental Services (DDS) program nationally. Over the past 25 years, the DDS network has spread to 40 states, and has engaged 15,000 volunteer dentists and 3,200 dental laboratories in donating comprehensive treatment services to patients who cannot afford care and do not qualify for public aid. The DLN national safety net program provides limited services in the remaining 10 states and the District of Columbia. Collectively, these programs have generated $200 million in services for 103,000 vulnerable people.

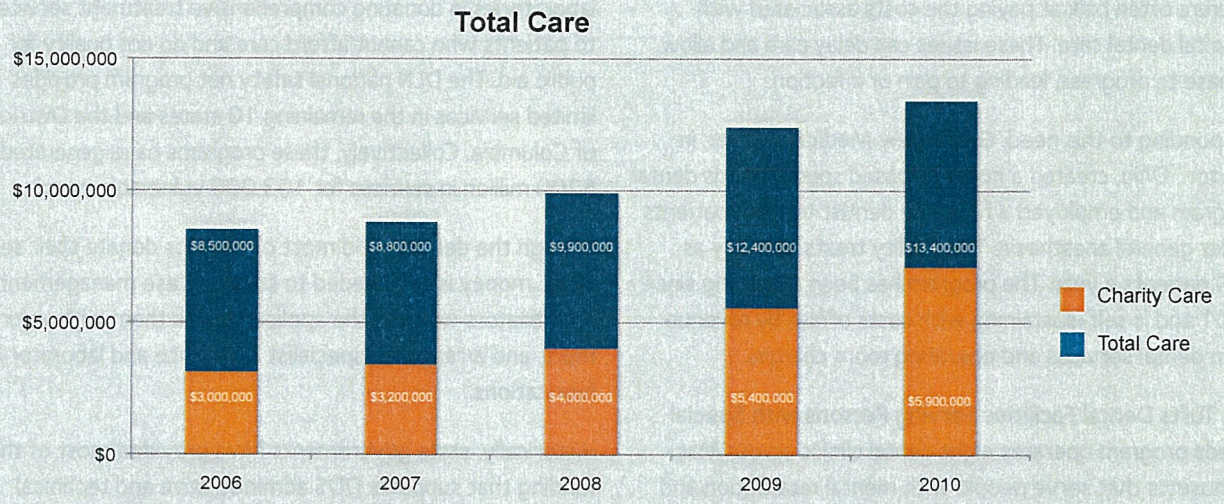
Though the dentists and most of the labs donate their services, money is still needed to support case management by coordinators who vet the applicants, link them with volunteers, and arrange for specialist assistance and laboratory fabrications.

Historically, state governments have provided most of the funding that supports DDS administrative and technical support services. But over the past few years, these programs have suffered significant cuts, especially in some of the larger states. From 2009 through 2011, state funding was cut $447,555, which ultimately caused the complete elimination of programs in Illinois, Kansas, Louisiana, Oregon, Pennsylvania and Minnesota. Absent a way to replace this lost funding, DLN's ability to administer and coordinate care delivery will suffer significantly.

Apple Tree Dental is a private, non-profit organization in Minnesota that provides oral health care to people with special needs, primarily through mobile units that bring dental care to nursing homes, Head Start and learning



Apple Tree Dental's Delivery of Charitable Care



centers, and group homes. It is also involved in advocacy, education, research, and program replication activities.

Apple Tree's revenues have increased steadily, allowing the clinic to deliver commensurate amounts of charity care.

Apple Tree is a unique organization designed to meet the needs of specific populations in specific places. But its mission, services and business model are adaptable to any number of settings, using revenue margins from privately insured or Medicaid patients to provide substantial amounts of care to people who otherwise would not receive it.

The Indian Health Service and Tribal Clinics

The Indian Health Service (IHS) is the principal federal health care provider and health advocate for American Indian and Alaska Native (AI/AN) people. The IHS provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to 564 federally recognized tribes in 35 states. Some tribes elect to manage their own health care systems, utilizing government funds without federal oversight. There are more than 300 dental clinics within IHS's 13 designated regions.

The ADA is a longstanding ally and supporter of the IHS, advocating on its behalf both individually and as a founding member of the Friends of Indian Health. While funding is always an issue, IHS is a prime example of how other factors, including geography, culture, staffing, facilities and co-morbidities can affect a delivery system and the overall health of the patients it serves. Until recently, the IHS suffered chronic dentist workforce shortages. Three years ago, 140 slots for IHS dentists lay vacant. Thanks in part to lobbying before Congress by the ADA and other allies, as of July 2011, there are only 39 vacant dental positions in the IHS system.

Several factors contributed to this success. The IHS over the past two years has recruited hundreds of dental students to work as summer externs. The students not only are exposed to rewarding experiences themselves, they also tend to become IHS evangelists upon returning to school. With student debt for dental school graduates averaging $200,000, the IHS loan repayment program or the option of becoming a commissioned officer in the U.S. Public Health Service is an increasingly attractive recruiting incentive.

American Indian and Alaska Native people have a significantly greater incidence of health problems than the U.S. population at large. AI/AN life expectancy is five years less than that for the general population. Death rates are significantly higher for diseases like tuberculosis, alcoholism, and diabetes. It is not surprising that oral disease affects Native populations at a higher rate as well.

According to data presented at a 2010 ADA symposium on early childhood caries (ECC) in American Indian and

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Alaska Native populations, the prevalence of ECC is about 300 percent greater in Native children than in all other U.S. ethnic groups. ECC is often much more aggressive and destructive in these children. In some communities, up to 50 percent of the children have such severe caries that they require full mouth restoration under general anesthesia—a rate about 50 to 100 times that in the general population. As the newspaper *Indian Country Today* recently put it, "The numbers are staggering."

Elevated disease rates among AI/AN peoples demonstrate the great need for safety net programs that focus more on education and prevention, rather than just treatment. Tobacco is the enemy of good oral health. Despite dramatic decreases in its consumption in recent decades, it remains prevalent in the same populations that suffer elevated levels of oral diseases. Excessive sugar consumption, associated with dental decay and obesity, also can aggravate such co-morbidities as diabetes, which can in turn increase the prevalence of gum disease. While the links among these conditions need much more research, it doesn't take a peer reviewed study to prove that people who adopt healthy behaviors greatly reduce their disease risks.

In 2010, 25 percent of IHS patients received dental services of some kind. If Congress maintains or increases funding for IHS dental programs this percentage should improve. The ADA and state dental societies have been working for years to advance oral health outreach and raise awareness of oral health in Indian Country. Most recently the ADA, along with the dental societies in Arizona, New Mexico and the Dakotas, established the Native American Oral Health Care Project to address the imbalance in oral health among American Indians. Similar efforts are underway in other IHS areas.

Free Clinics

Writing in the Archives of Internal Medicine, Julie S. Darnell, Ph.D., M.H.S.A, calls free clinics "overlooked and poorly studied." As a result, she writes, "[P]olicy discussions have been forestalled and potentially fruitful collaborations between free clinics and other safety net providers have been hindered."

Approximately 1,000 free clinics operate in the United States, funded by a diverse array of sources, including hospitals, foundations, civic groups, corporations, religious institutions, and state and local governments. Some 35 percent of them provide on-site dental services. Collectively, free clinics account for an estimated 300,000 dental visits annually, with almost all of the care provided by volunteer private practice dentists at no charge.

Responding to the low numbers of dentists able to accept Medicaid-eligible patients, the **McHenry County (Ill.) Cooperative Dental Clinic** opened its doors nearly 15 years ago to provide free dental care to the working poor and indigent. The clinic has provided dental care for more than 26,000 patients who received services ranging from basic restorative care to limited periodontal and surgical procedures. Eighty percent of the clients are children; 75 percent are Hispanic/Latino. The center has expanded its reach by collaborating with McHenry County Dental Society members to offer specialty care as needed and emergency care during evenings and weekends. Dental society members have accepted more than 4,000 referrals from the clinic into their own practices, representing more than 7,000 volunteer hours.

Despite its proven success in providing care to underserved populations, this clinic still faces challenges penetrating cultural and educational barriers. For example, when children are identified in schools with urgent or routine dental needs, less than 10 percent of parents contact the clinic, even though the service is free. The center's research has found that 60 percent of participants in the Women, Infants and Children (WIC) nutrition program use non-fluoridated bottled water. Fifty percent of all WIC clients refused fluoride varnish for their children younger than three years.

To compensate for low patient literacy, the clinic has added two staff members to provide individual education and assistance in filling out consent forms and surveys and to increase participation in the varnish program. Clinic data indicate that despite prenatal and infant oral health education, much of its patient base is unable to recognize a dental need, even in cases of rampant early childhood caries. Typically, parents only seek treatment when their children are old enough to communicate that they are in pain.

Dental Students, Residents and Faculty

Fifty-six of the 58 U.S. dental schools provide some degree of primary and specialty care for underserved people. In addition to the immediate health benefits to the patients they serve, these programs instill in dental students and

residents a sense of the personal rewards to be derived from helping those in greatest need. While the majority of students will eventually end up in private practice, their broadened understanding of public health, and seeing the human face of "underserved populations" can orient them toward devoting at least some of their practice hours to caring for patients in need, as so many private practice dentists do throughout their careers.

- **Ohio State University College of Dentistry's OHIO Project** provides dental services at more than 15 clinic sites in central and southern parts of the state, with high student involvement. The project includes the Dental H.O.M.E. (Health Outreach Mobile Experience) Coach, a bus equipped with three operatories, which serves children in need in Columbus public schools. The school's other initiatives include programs that provide care to elderly patients in rural Appalachian counties, nursing homes and adult day care facilities.
- **University of Southern California (USC) - Herman Ostrow School of Dentistry** partnered with Queens-Care, a non-profit healthcare provider for low-income Angelenos, to provide free, comprehensive dental care to children in grades 2 through 5 at Hollywood-area elementary schools. Utilizing mobile dental units, USC faculty and students provide comprehensive dental care and oral health education to more than 13,000 children every year. The school's mobile clinic has served more than 80,000 children and has been a required clinical rotation for all dental students since 1994.
- **University of Pennsylvania – Penn Dental Medicine's** students log an aggregate 9,600 service hours each year, serving more than 20,000 residents in surrounding Philadelphia neighborhoods. The school allows students to choose among a variety of outreach programs, among them PennSmiles, an oral health initiative with the Philadelphia School District; HIV/AIDS Oral Health Outreach, clinics for the homeless, and a program for geriatric patients.

Dental education experts estimate that as many as 20 new schools could open in the next 10 years, and that some existing schools will increase class sizes, leading to even greater contributions from the education sector to the provision of care to underserved populations.

Graduate Dental Education

Dental school graduates who continue their training in general dentistry or in specialties such as endodontics, periodonitics, pediatric dentistry, oral and maxillofacial surgery, orthodontics, or public health dentistry are another vital element in the safety net. Whether providing care in hospitals or working in safety net clinical settings, dentists in these training programs (residencies) enhance the level of specialty care accessible to the underserved, while increasing the confidence and skill level of general practitioners working alongside them in clinics, especially with regard to managing patients across the spectrum from infants to pregnant women to medically-compromised people.

According to the 2009-10 Survey of Advanced Dental Education, there are 724 accredited post-graduate dental programs roughly split between dental schools and other settings. Most of the non-dental school-based residency programs are housed in hospitals and academic medical centers. They include 152 specialty programs and 226 postdoctoral general dentistry programs. In total, these programs enroll more than 6,000 residents who spend the majority of their time treating patients in hospital and ambulatory care clinics. In many settings these residents often are components of interdisciplinary, interprofessional teams that provide patient access to comprehensive, coordinated, cost-effective health care. These training programs also expose residents to diverse populations and underserved areas, which can help to address disparities in the distribution of dentists with advanced general and specialty expertise.

This confluence of a hospital setting and dental specialty instructors and trainees makes the difference between treating disease or letting it worsen for patients who cannot obtain care elsewhere. Like the larger safety net, the dental postgraduate system itself is continually at risk, subject to fluctuations in federal and state funding that covers part of the cost of these programs.

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Use of Hospital Emergency Departments for Oral Health Care

As the economy has worsened and stagnated, and safety net dental programs suffer cutbacks, hospital emergency departments increasingly bear the burden of oral health emergencies, a large portion of which are preventable. An August 2010 HRSA-funded study found that oral health problems account for between 1.3 percent and 2.7 percent of all ED visits that do not result in an inpatient admission. This equates roughly with the total percentage of ED visits for psychological and mental symptoms (2.2 percent) and is greater than the percentage of visits for cardiovascular symptoms.

While these percentages may appear small, the real numbers they represent are not. The HRSA ED report enumerates visits in a sampling of states, including Arizona (23,113), Florida (34,805), Iowa (11,351), Maryland (30,096), Utah (8,513), Vermont (5,936) and Wisconsin (25,991). Approximately half of these "emergencies" resulted from preventable conditions which, owing to the lack of regular dental care, deteriorated to the point where the patient was in sufficient pain to seek emergency care. The worst part of the equation is that most of these patients do not receive *dental* care during these episodes. Instead they typically are given antibiotics and pain relievers, which relieve the symptoms temporarily. But absent dental treatment, such symptoms generally return, often engendering the same fruitless cycle, not solving the real problem while contributing to the continuing increases in health care costs borne by all.

Private Practice—Where the Dentists Are

Less than two percent of the nation's dentists work full-time in what can be called safety net settings. The vast majority of the remainder works in private practice, meaning that the private practice community is the greatest provider of hands-on care to safety net populations and will be for the foreseeable future. Dentists provide most of this care for inadequate reimbursement or, in many cases, free of charge. Although administration and financing of public assistance health programs reside almost entirely with federal and state governments, the private sector is where the dentists are.

The majority of privately delivered dental care to the underserved is funded by Medicaid and the Children's Health Insurance Program (CHIP). These programs in too many cases embody the safety net's greatest failings. But they also hold the greatest promise for its improvement if properly administered and adequately funded.

State Medicaid and CHIP programs should be the backbone of the safety net, but they are beset by chronic problems. Lawmakers tend not to understand the degree to which the lack of access to oral health services affects not only people's health, but also the overall quality of their lives.

Use of Hospital Emergency Departments for Oral Health Care

A 2011 position paper from the South Carolina Dental Association clearly illustrates the process:

Treatment of Patient with abscessed tooth

Emergency department

Hospital ER Charge	$76
X-Ray	$102
Physician Fee	$33
Radiologists Fee	$25
Total Cost to Medicaid:	**$236**

Result: Palliative care through antibiotics and pain medication. Problem is not solved and likely will recur, perhaps resulting in another ED visit.

Dental office

Problem Focused Exam	$38.34
X-Ray	$13.65
Extraction of Tooth	$55.24
Total Cost to Medicaid:	**$107.23**

Result: Problem is solved. No further treatment necessary.

Despite increases in the amount of time dental students spend caring for underserved populations, too many graduates remain inadequately prepared to incorporate these patients into their private practices. Virtually every state's Medicaid program is underfunded and many labor under inefficient administrative structures. Dental and medical homes often lack coordination, perpetuating a lack of emphasis on preventive care for Medicaid-eligible children.

If those numbers are to increase nationwide, Medicaid and CHIP programs must realign their priorities, placing greater emphasis on oral health. Some states have devised programs that significantly reduce major barriers, increasing the numbers of both participating dentists and patients receiving care to well above the national averages.

Even highly successful program reforms are not guaranteed to last. What the state gives, it can just as easily take away.

- **Alabama** established *Smile Alabama!* in October 2000, increasing reimbursement rates to 100 percent of the Blue Cross Blue Shield dental fee schedule and improving administrative procedures for participating dentists. The state invested $1 million of private funding in outreach activities, partnered with a dental advisory group, and collaborated with the state dental association to improve access. Alabama also simplified its claims processing system and increased patient education and care coordination services. **Alabama program reform results:**
  - 76 percent increase in eligible children utilizing services
  - 76 percent increase in participating dentists
- **Connecticut**, prior to a 2009 Medicaid fee increase, had fewer than 200 participating dentists, leaving many children with months-long waits for treatment. Increasing the fee schedule to the 55th percentile increased the numbers of participating providers and, most important, the number of children receiving treatment dramatically. **Connecticut program reform results:**
  - Increased the number of participating dentists to more than 1,200
  - Children needing emergency treatment wait no longer than 24 hours
  - Waiting time for routine appointments reduced to a maximum of 20 days
  - Percentage of eligible children receiving treatment increased from about 15 percent to more than 45 percent
- **Michigan**: The state Medicaid program in 2000 entered an arrangement with a private insurer that began with the state's CHIP program. Under Healthy Kids Dental, most providers were reimbursed at 100 percent of their usual charges for that insurer. Enrollees gained access to the large pool of the insurer's participating dentists. Providers who already contracted with that insurer were able to integrate a new group of patients into their practices with no major administrative headaches. In fact, treating dental offices do not need to know whether a child is covered by Medicaid or the private insurer that administers Healthy Kids Dental, because public- and private-pay patients are handled identically. Despite the program's success, the state has so far balked at allocating an estimated $29 million needed to extend the program statewide, most notably to its major urban centers. **Michigan program reform results:**
  - 43 percent increase in eligible children utilizing services
  - 150 percent increase in participating dentists
- **South Carolina** in 1998 improved its administrative processes and eventually increased its reimbursement rates to those that 75 percent of a group of surveyed dentists found acceptable. Part of the program's success owes to the state having worked closely with the South Carolina Dental Association. The state also received private funding for outreach, especially to rural areas. **South Carolina program reform results:**
  - 54 percent increase in eligible children utilizing services
  - 93 percent increase in participating dentists
- **Tennessee** "carved out" dental services from its TennCare medical managed care contracts in 2002, and contracted with Doral Dental. Reimbursement rates were increased to the 75th percentile of the 1999 ADA Survey of Fees for the East South Central region, and program administration was streamlined. **Tennessee program reform results:**

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- 38 percent increase in eligible children utilizing services
- 120 percent increase in participating dentists

- **Virginia** instituted Smiles for Children in 2005, carving out dental benefits and establishing a single benefits administrator. The state Medicaid agency and Virginia Dental Association worked closely to secure a 28 percent increase in reimbursement for all dental procedures, and an additional 2 percent rate increase for oral surgery procedures. **Virginia program reform results:**
  - 33 percent increase in eligible children utilizing services
  - By 2009, 1,264 dentists were enrolled Medicaid providers, a 103 percent increase since 2005.

Reality Check: The state Medicaid/CHIP program reforms detailed above show some dramatic increases in both patient utilization and dentist participation when expressed as percentage increases. But a look at the hard numbers puts those percentages in perspective. Of the five states listed above, none had actual utilization rates greater than South Carolina's 43 percent, meaning that the majority of each state's eligible children still went without a dental office visit in 2006. Inarguably, increasing Medicaid and CHIP reimbursement rates will encourage more dentists to participate in those programs and therefore increase capacity to treat patients. But equally inarguable is that rate increases alone will only move the program so far absent other measures.

Significantly, program reforms, even those that succeed handily, are by no means assured longevity. What the state gives, it can just as easily take away. Georgia provides a cautionary tale. Responding to an urgent plea for help from the Commissioner of the state Department of Medical Assistance, the Georgia Dental Association in 2000 launched a successful legislative campaign to reform the state's dental Medicaid system. The GDA followed through with a major effort to encourage its members to participate in the improved system. This "Take Five" initiative urged dentists to take on new Medicaid patients. Key to its success was the flexibility with which it urged private practice dentists to participate commensurate with their experience and comfort with caring for patients in public assistance programs—five patients total, five a month, pretty much five of anything. Within 18 months, the number of dentists participating in Medicaid went from fewer than 300 to nearly 1,900.

The success was short-lived. In 2006, both Medicaid and PeachCare for Kids (Georgia's CHIP program) adopted a privately contracted system that required participating dentists to sign contracts with three care management organizations. These CMOs began terminating providers, closing panels and ratcheting down reimbursements. The CMOs proposed and the legislature approved fee cuts of a minimum 15 percent, with reimbursement for some fees cut by up to 61 percent.

Some of the terminated dentists had established their practices assuming a Medicaid/CHIP patient base, meaning they had been caring for the greatest numbers of enrolled patients. While the CMOs argued that more than 900 dentists were still providing services to the Medicaid and CHIP populations, the Centers for Medicare and Medicaid Services reported that fewer than 400 of those dentists had filed claims for more than $10,000. The remaining 500 providers apparently were registered with Medicaid or PeachCare, but were not actually treating the programs' patients to any meaningful degree.

Adult Medicaid Coverage: Federal law requires states to provide a specific package of dental benefits to children in the Early and Periodic Screening, Diagnosis and Treatment provision. That said, states still enjoy considerable latitude in deciding which children are entitled to this coverage, which can exclude many kids from families whose incomes can't cover dental care but still exceed the state's poverty threshold. As shaky as children's coverage can be, Medicaid coverage for adults is much worse. The accompanying chart shows only 13 states reporting anything more than "limited" dental coverage for adults. And while those 13 states report their adult coverage as "comprehensive," there is not a common definition for comprehensive.

Adult Coverage

Services Provided	Medicaid Adult Benefits	Medicaid Benefits for Pregnant Women	CHIP Adult Benefits
None	7	14	38
Emergency Only	15	5	2
Limited	15	14	3
Comprehensive	13	16	7
Not Reported	1	2	1

NOTE: Includes all states and the District of Columbia
Source: Association of State and Territorial Dental Directors Synopses of State Dental Public Health Programs, June 2011

Further, the eligibility requirements—which vary from state to state—can still rule out benefits for most low income adults. The most critical attribute of adult Medicaid dental coverage is the one that makes it so difficult to quantify. Coverage for adults changes so frequently—mostly for the worse—that tracking it accurately would require almost real-time surveillance.

A common theme to all of these examples—good and bad—is that collaboration among relevant government agencies, state and local dental societies and other public and private stakeholders is essential to creating and sustaining successful safety net programs. As one dental society executive puts it, "It's all about relationships."

The Role of Charity

In 2007 alone, the most recent year for which figures are available, private practice dentists provided some $2.16 billion in free or discounted care to disadvantaged children and adults. They do so both individually and as part of programs organized by state and local dental societies, the ADA and others.

Missions of Mercy (MOM) are in essence temporary dental field hospitals. While they now operate with some financial and technical support from America's Dentists Care Foundation, they generally are organized and executed by state dental societies. They have taken place in remote rural areas, suburbs and cities, wherever there are sizable populations of people who are not getting dental care and suffering the consequences. They are lifelines especially for low- or no-income adults who are not eligible for Medicaid or other public assistance programs.

The ADA's Give Kids A Smile (GKAS) program began as a one-day-a-year nationwide event in 2003, taking place on the first Friday in February as a kickoff for National Children's Dental Health Month, with the sole purpose of providing free dental services to disadvantaged children. Although most GKAS activity continues to occur on that day, programs are now taking place throughout the year. So far in 2011, nearly 12,000 dentists aided by 33,000 other volunteers (including dental hygienists, assistants, other health professionals and lay volunteers) have provided services to an estimated 400,000 disadvantaged children at 1,862 sites nationwide.

GKAS has in recent years focused increasingly on providing continuity of care for the underserved year round. The GKAS program has convened symposia largely focused on the importance of finding dental homes for disadvantaged children. The ADA Foundation has in 2011 awarded Continuity of Care Grants to seven GKAS programs. Grantees will use these funds to establish systems designed not only to provide free restorative care, but also to help these children's families find dental homes.

A report from a recent MOM in Wisconsin depicts a typical event, this one held at a field house in Weston, Wis.

The first patient arrived 36 hours in advance and slept in his car Wednesday night before setting up a lawn chair outside of the clinic entrance around 10 a.m. Thursday. Clinic doors opened at 6 a.m. Friday, with care concluding at 5:30 p.m. Saturday. A total of 8,033 dental procedures were performed, including 1,822 fillings, 1,756 teeth extracted, 593 cleanings and 22 root canals. Several dental labs worked with volunteer technicians to create 90 partial dentures. An estimated $1.12 million in charitable dental care was provided to 1,570 children and adults.

Patients ranged from a 10-month-old girl to a 91-year-old man, and included 22 Special Olympics Wisconsin athletes. Some 215 dentists, along with dental hygienists and assistants and Marquette University School of Dentistry students were among the 1,050 volunteers.

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Based on the best available estimates, the vast majority of charitable care takes place without fanfare in private dental offices throughout the year. But events like GKAS and MOMs serve the additional purpose of raising awareness among the media, law- and policymakers and the general public of the importance of oral health to overall health, and to the terrific need that exists among millions of Americans who go without care every year, some for years on end. Even as the private practice community is delivering billions in charitable care yearly, its overarching message is that charity is not a health care system, and that no one should have to rely on it to achieve good oral health.

Non-Clinical Support Services

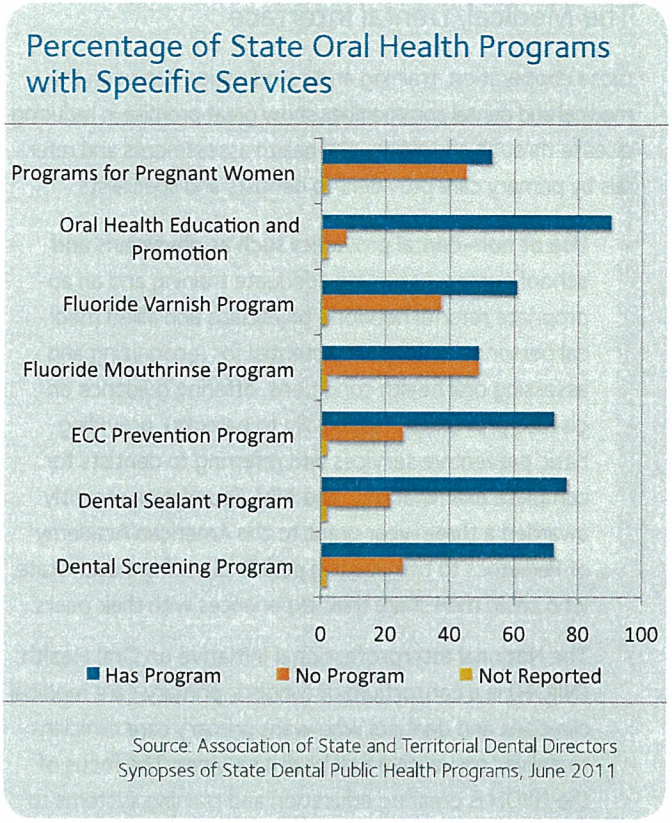
HHS Oral Health Initiative 2010

The U.S. Department of Health and Human Services supports a broad spectrum of activities aimed at improving the nation's oral health through financing, research, workforce development, public health action, quality initiatives and technology. In late 2009, HHS Assistant Secretary Howard Koh, M.D., M.P.H., called for the implementation of an agency-wide effort to improve the nation's oral health by realigning existing resources and creating new activities. This effort sought to increase coordination and integration among programs to maximize outputs.

The initiative creates and finances programs to emphasize oral health promotion and disease prevention; increase access to care; grow the oral health workforce and generally eliminate disparities. An Oral Health Coordinating Committee is currently compiling a resource guide of all HHS oral health initiative and efforts, with the intent of breaking down "stovepipes" and enhancing collaboration across the department.

Unfortunately, the federal oral health infrastructure cannot live up to these goals so long as Congress and the executive branch neither recognize nor adequately address the importance of oral health. The current lack of permanent chief dental officers within the Centers for Medicare and Medicaid Services (CMS), HRSA and the Centers for Disease Control and Prevention (CDC) further complicates the issue.

State Oral Health Programs play a critical role in supporting the safety net by tracking dental disease rates, and by promoting and supporting population- and evidence-based prevention strategies such as community water fluoridation and school-based sealant or fluoride varnish programs.



But federal and state support for these programs is tenuous and, in many cases, shrinking. This tendency both worsens and is worsened by the high turnover among state dental directors, who increasingly and understandably grow frustrated and ultimately discouraged. The absence of seasoned and determined state dental directors only furthers the unraveling of an already inadequate safety net.

Not surprisingly, the current economy is punishing state oral health programs, with nearly half of the states having decreased their funding in FY 2010 over the prior year. During that year, CDC supported infrastructure and capacity enhancements in only 19 state oral health programs. Many others were approved for enhancements but were left unfunded.

The Medical/Dental Interface

Close cooperation, training and coordination between the medical and dental communities show great promise in reducing disease through education, oral health assessments and referrals by primary care providers to dentists and specialists.

- **Use of non-dental providers such as physicians and school nurses.** Assuming adequate training and an appropriate referral network, physicians and allied medical personnel hold great potential for recognizing and assessing oral health conditions, offering guidance on disease prevention (especially to parents), providing basic preventive services and referring to dentists for complete examinations. The ADA Foundation recently awarded a three-year grant to the American Academy of Pediatrics to train leading pediatricians from each state, who could then share their experiences with their peers.
- **The National Interprofessional Initiative on Oral Health (NIIOH)** is a consortium of funders, primary care medical clinicians and dentists who want primary care clinicians to deliver preventive oral health services. The focus of the NIIOH is creating education and training systems to prepare primary care clinicians for practice, including addressing oral health as an integral part of patient care.

New Dental Workforce Models

For the past few years an increasingly heated debate has centered on proposed workforce models that would have non-dentists—generally referred to by their proponents as dental therapists—performing such surgical/irreversible procedures as restorations, extractions and even pulpotomies, the surgical removal of pulp from the tooth structure.

The ADA remains unequivocally opposed to proposals for these so-called "midlevel providers," believing that adding lesser-trained "surgeons" to the workforce has the potential to erode the superlative quality of American dental care. They are based on incorrect assumptions about the capacity of the existing and future dentist workforce to deliver these services. They risk further fragmentation of an already uncoordinated safety net. They fail to address adequately the major, underlying problems in improving the oral health of the underserved—oral health education and prevention.

This is not to say that workforce innovations cannot improve the oral health of underserved populations. In 2006, the ADA launched a pilot program to educate Community Dental Health Coordinators (CDHCs) to work in such chronically underserved areas as inner cities, remote rural areas and American Indian communities. The CDHC is based on the community health worker model, which has proven extraordinarily successful in medicine. While CDHCs are able to perform limited clinical procedures, their major functions are oral health education, disease prevention and helping those in need of care navigate an often complex and unwelcoming web of red tape. CDHCs also help patients deal with ancillary needs such as transportation, child care or getting permission to miss work in order to receive dental care. They are typically recruited from the same communities in which they will serve, which essentially eliminates the language or cultural barriers that otherwise could impede their effectiveness.

A prior ADA paper, *Breaking Down Barriers to Oral Health for All Americans: The Role of Workforce* (February 2011) explores these issues in greater detail.

Repairing the Safety Net

Major improvements in the dental safety net will not occur until the nation places greater value on oral health. Despite a growing appreciation in many quarters that oral health is integral to overall health; it remains the poor stepchild of health care in America. This phenomenon extends from government to the media to other health professions to the public at large. This lack of recognition of the importance of oral health is manifest in government policy, in public and private health plans, in the educational system and even in the priorities that individuals set for themselves and their families. Utilization rates are low, even among disadvantaged populations who are covered by some sort of dental program. Millions of Americans who have private dental insurance or the means to pay out of pocket do not seek regular dental care for a variety of reasons, including fear or the misapprehension that if they are not in pain, they don't need care.

Lack of money has always been and will remain a critical barrier. But the safety net can be improved even in the event that Congress revises the Patient Protection and Affordable Care Act to cut what otherwise will be a major funding infusion. It simply points to the importance of a better coordinated system that maximizes resources, minimizes redundancy, coordinates care, and effectively and thoroughly integrates with the private practice delivery system. This paper contains numerous examples of systemic changes at the federal, state

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and local levels that either have advanced or could advance these goals. A major impediment is lack of commonality and communication, even among confirmed safety net advocates. In recent years, this has been embodied by rancorous disputes over the dental workforce.

The ADA believes that the available population of dentists is not a primary issue, and that precious resources should not be squandered on unnecessary efforts to augment the workforce with midlevel providers. Adding new dental team members to a fragmented, uncoordinated set of services, whether dentists or proposed midlevel providers, will not appreciably improve the situation. The problem is not how many dentists there are; but rather where they are, and whether they are able to serve disadvantaged patients, either in private practices or in connection with clinics, health centers or other facilities.

departments, social services agencies and partnerships with the nonprofit and private sectors. Many communities could avail themselves of such resources as pediatricians and family practice physicians, midwives and obstetricians, school nurses, Head Start and WIC staff and *promotoras*. In addition to mobilizing these existing human assets, training a large force of Community Dental Health Coordinators could significantly strengthen efforts to stop oral disease before it starts.

At the federal level, the various HHS agencies with oral health components need better communication and coordination and, most pointedly clout. All of them must have discrete dental divisions with chief dental officers in place. Each of the 10 HHS regional offices should have a full-time oral health consultant with sufficient time, budget and expertise to provide technical assistance to HHS grantees, particularly health centers.

Programs that provide incentives for dentists to practice in safety net settings have proven successful and should be expanded at the federal, state and local levels.

Programs that provide incentives for dentists to practice in safety net settings have proven successful and should be expanded at the federal, state and local levels. Recent surveys have shown high personal satisfaction among dentists and allied personnel working in these community-based settings, indicating that they are likely to stay in them even after they have met their obligations for loan repayment or other incentives. In addition, the private practice community—where the great majority of dentists are—has yet to be fully utilized as an adjunct to safety net facilities. Better collaboration and exchange of knowledge between the public and private sectors is essential.

The public health and private practice dental communities must be better engaged. Although 69 percent of health center dentists are ADA members, professional interaction between these dentists and their private practice colleagues is marginal at best. Every health center board of directors should include a private practice dentist from the local community. Experienced private practice dentists acting as mentors could greatly assist less experienced health center dental directors in both program leadership and management.

Communities must increase their oral health education and disease prevention efforts, through schools, local health

Fortunately, the ADA is far from alone in recognizing the anemic state of the safety net. While not in lockstep on every issue, the leading agencies, organizations and individuals agree on most of the critical principles needed to repair it. For example, the Institute of Medicine (IOM) this year released the second of two reports to HRSA on improving access to oral health care. Most of the IOM's key recommendations echo positions and policies that the ADA has long held, including strengthening Medicaid and CHIP, broadening patient case management and increasing the role of academic dentistry in the safety net.

The common thread throughout the numerous and diverse safety net elements explored in this paper is their tentative status. Programs are slashed or cut entirely due to budget pressures at all levels of government; administrative systems that work well are neglected and fall into dysfunction. Dentists who have dedicated themselves and foregone more lucrative practices in order to care for the underserved struggle to do so in increasingly difficult circumstances. Most important, people who deserve better continue to suffer from poor oral health and its severe consequences.

No major infusion of federal or state money into dental care for the underserved can realistically be expected in the foreseeable future. But significant improvements in the safety net can occur with minor funding increases and major improvements in coordination, communication and collaboration.

A comprehensive, coordinated approach for health education and promotion, care coordination and effective prevention is critical to improving the oral health of the underserved. The ADA is committed to working with all stakeholders to repair and grow the oral health safety net. Our degree of success will hinge on these fundamental principles:

- **Prevention is essential.** A public health model based on the surgical intervention in disease that could have been prevented, *after* that disease has occurred, is a poor model. The nation will never drill, fill and extract its way to victory over untreated oral disease. But simple, low-cost measures like sealing kids' teeth, educating families about taking charge of their own oral health, expanding the number of health professionals capable of assessing a child's oral health, and linking dental and medical homes will pay for themselves many times over.

- **Everyone deserves a dentist.** The existing team system of delivering oral health care in America works well for patients in all economic brackets. It does not need to be reinvented. Rather, it needs to be extended to more people. Creating a separate tier of care for underserved populations will sap resources from solutions that already work, and will do comparatively little to improve the oral health of those in greatest need.

- **Availability of care alone will not maximize utilization.** In too many cases, people are unable or unwilling to take advantage of free or discounted care. Many dentists who treat Medicaid patients must

contend with a much greater incidence of missed appointments than they experience with non-Medicaid patients. These missed appointments represent erosion of available treatment time that the system cannot afford to waste. This owes partly to the need for better attention to social or cultural issues, oral health education, and greater support for patients who need help with transportation, child care, permission to miss work or other non-clinical services.

- **Coordination is critical.** Too many government and government-administered programs suffer from a failure to manage and exchange information about best practices for safety net operations. Technology and human capital are available to remedy this. Political will is key to better leveraging these resources.

- **Treating the existing disease without educating the patient is a wasted opportunity, making it likely that the disease will recur.** Anyone who enters a dental operatory for restorative care should leave that operatory with an understanding of how to stay healthy and prevent future disease. Excessive alcohol or sugar consumption can increase the risk of oral disease. Tobacco use in any form increases the risks for gum disease and oral cancer. Educating patients about these risks and how to reduce them should be incorporated into every possible patient encounter.

- **Public-private collaboration works.** Absent a highly unlikely population boom among dentists practicing in community-based and public health settings, private practice dentists will continue to deliver the hands-on care to most of the population, regardless of payment mechanism. Public health and assistance programs can simplify their administration, reducing red tape and assisting patients with related, non-clinical needs. Make it easier for the dentists to deliver care and the safety net will address the oral health needs of more patients.

- **Silence is the enemy.** Let's take the "silent" out of "silent epidemic." Virtually every shortcoming in the safety net has at its root a failure to understand or value oral health. When people, whether lawmakers, the media or the general public, learn about oral health and the consequences of oral disease, their attitudes and priorities change. Awareness is on the rise, but we have far to go before Americans know enough to make the personal and policy decisions that ultimately will create a real safety net, one that prevents oral disease and restores oral health in people who seek healthier and more productive lives.

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America's leading advocate for oral health

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