

Julie Stitzel
Manager, Pew Children's Dental Campaign
The Pew Charitable Trusts

Statement before the North Dakota Senate Health Services Committee

October 30, 2013

Madam Chair and Members of the Committee, thank you for holding this hearing and for the opportunity to testify. My name is Julie Stitzel, and I am a manager for The Pew Charitable Trusts' Children's Dental Campaign. I am pleased to appear before you today to provide national and North Dakota-specific data on oral health access. The Pew Children's Dental Campaign works to improve children's dental health by advocating for more prevention, adequate funding for care, and ensuring there is a sufficient workforce to care for low-income children. Within that framework, we help state and national partners achieve the evidence-based solutions they have chosen.

Access to dental care in the United States

Each year in the United States, tens of millions of children, disproportionately low income, go without seeing a dentist. In at least 22 states, less than half of Medicaid-enrolled children received dental care in 2011.¹ As of last Thursday, the U.S. Department of Health and Human Services reported that roughly 43.5 million Americans live in "shortage areas"—regions that have a scarcity of dentists relative to the population.²

Unlike the medical team, which includes a wide variety of practitioners at different levels, the current dental workforce is limited to dentists, dental hygienists, and dental assistants. More than a dozen states are considering licensing additional dental professionals, similar to physician assistants on a medical team, who would expand the reach of the dental team—especially in rural communities. These providers, who cost less to train than dentists, have the opportunity to bring care closer to patients in places like schools, nursing homes, mobile dental clinics and other sites in the community. They can even work in private dental offices to help dentists serve more low-income patients.

Lack of access to dental care is leading more and more people to turn to hospital emergency rooms (ERs) for preventable dental conditions. These ER admissions impose a significant and unnecessary burden on state budgets. According to the American Dental Association's Health Policy Resources Center, the number of dental ER visits in the U.S. increased from 1.1 million in 2000 to 2.1 million in 2010—nearly double. Based on various estimates of the average cost of a dental ER visit, emergency room visits to treat dental conditions cost the health care system anywhere from \$867 million to \$2.1 billion every year.³

Furthermore, hospitals are generally unable to treat conditions such as dental abscesses and toothaches, as almost no ERs have dentists on staff. Sadly, the ER visit typically results in the patient receiving prescriptions for pain killers and antibiotics, and advice to see a dentist. Many patients who leave without the underlying dental problem addressed often return to the ER later as their condition deteriorates, for care costing far more than services provided in a dental office

or clinic. There are no ready data to assess ER use for preventable dental conditions across the entire population in the state. But a number of sources reveal it is a significant problem. For instance, the Medcenter One Emergency and Trauma Center in Bismarck has tracked ER visits from patients with dental complaints for several years. In 2011, dental complaints were the third most common of all complaints reported by ER patients.⁴ From 2010 through 2012, North Dakota spent \$230,853 on emergency room visits by Medicaid-enrollees for preventable dental conditions.⁵ Simply put, it is the wrong care, at the wrong time, in the wrong setting and it is costing North Dakota taxpayers.

Access to dental care in North Dakota

Advocates for oral health in North Dakota have made strides to improve oral health and increase access to dental care in the state. On a number of fronts, the data are encouraging. For example, in 2010, North Dakota was fifth best among states in the percent of the population served by fluoridated community water systems (96.9%).⁶ North Dakota is also one of only a few states in the U.S. that still provides an adult dental benefit for the Medicaid insured. And the state is performing well in providing sealants to low-income children. According to Pew's 2013 report grading all states on their sealant performance, North Dakota was only one of five states to receive an "A."

But on measures of access to care there are still problems, especially for Medicaid-eligible children, rural residents, low-income adults, the elderly, and Native Americans. And data show that between 2010 and 2012, the portion of residents who had visited either a dentist or a dental clinic actually declined by more than 5 percentage points, resting at 67 percent.⁷

It is striking that in 2011, 66 percent of Medicaid-enrolled children in North Dakota did not receive dental care.⁸ While the North Dakota Legislature has raised Medicaid reimbursement rates for dental care recently, these increases for the most part do not cover the cost for the actual service provided.

In the summer of 2012, Pew partnered with the Otto Bremer Foundation and hired the Center for Health Workforce Studies at the School of Public Health, SUNY Albany to assess the status of oral health in North Dakota. The research involved a literature review, data analysis, and interviews with 48 state-based experts in oral health. This study identified distant rural counties with high numbers of Medicaid-eligible children that do not have a single dentist to serve their oral health needs. For example, there are 3,000 children enrolled in Medicaid in Rolette County with no dentist in the county to serve them. There are some dental services available to children on the American Indian reservation, but generally families must travel long distances to get services. The closest pediatric dentist to Rolette County is in Minot, which is about a two-hour drive.⁹

Lack of access to dental care is not just a problem for children. The elderly, particularly those living in nursing homes in North Dakota, and low income adults without dental insurance, have few options.

North Dakota's oral health workforce and safety net

In 2012, there were 360 licensed dentists and 518 licensed dental hygienists with practice addresses in North Dakota.¹⁰ There has been an increase in the number of dentists licensed in

North Dakota in recent years; however, despite the growing number, 28 counties in North Dakota contain at least one dental professional shortage area.¹¹

There is a surplus of dental hygienists in North Dakota, with 83 licensed hygienists who do not list an address where they practice. In fact, in a 2012 report, some dental hygienists reported working as dental assistants while others reported working in non-oral health jobs because of the lack of opportunities in dental hygiene. The oral health workforce in North Dakota is mainly distributed in the metropolitan areas of the state like Fargo and Bismarck.¹²

There is a limited safety net for oral health services located mainly in North Dakota's largest cities—Fargo, Bismarck and Grand Forks—and in a few rural areas. North Dakota's safety net is comprised of four federally qualified health centers, two not-for-profit dental clinics and a mobile van serving children. There are a number of areas of the state where there is no safety net dental provider within a reasonable driving distance of much of the population.¹³

Safety net providers of oral health services—practitioners who deliver a significant level of care to the uninsured, Medicaid, and other vulnerable patients—are limited in the number of patients they can serve due to space and financial constraints. Additionally, some safety net providers in North Dakota experience such demand for the dental services they provide that they must limit the service area from which patients are drawn – because they do not have the capacity to meet the need.¹⁴

Exploring Solutions

In 2011, persistent lack of access to dental care led the Institute of Medicine (IOM) to study the issue. The IOM recommended that states amend their dental practice acts to use dental auxiliaries to the full extent of their training and that states deploy additional types of dental providers, like dental therapists, in more settings to help solve the growing access problem.¹⁵

These providers are already practicing in Minnesota and Alaska. Even after the Minnesota Legislature expanded the roles of dental hygienists, state lawmakers took the additional step of enacting a law creating two types of additional dental providers—the dental therapist and advanced dental therapist. Preliminary data indicate they are having a positive impact on increasing access to care for those who need it most, in a financially sustainable way. In fact, while many of these providers work in community clinic settings, a private practice dentist in rural western Minnesota has also hired one. This has allowed him to serve many more Medicaid patients while increasing profits.

California is considering adopting a change to the way dental care is delivered by expanding the scope of practice for dental assistants and dental hygienists while using technology to connect them with their supervising dentist. This model is known as the Virtual Dental Home (VDH). It is an innovative and cost-effective system for providing dental care to California's most vulnerable children and adults. Through the VDH—a demonstration project, directed by the Pacific Center for Special Care at the University of the Pacific School of Dentistry—dental hygienists and assistants examine and collect dental information from patients in community settings—such as schools, Head Start sites, and nursing homes. They send that information electronically via a secure Web-based system (called store-and-forward telehealth) to the supervising dentist at a clinic or dental office. The dentist uses that information to create a dental

treatment plan for the hygienist or assistant to carry out. The hygienists and assistants refer patients to dental offices for procedures that require the skills of a dentist. Over 2,000 patients have been seen in more than 45 sites around California with overwhelmingly positive results.¹⁶

The Children's Dental Campaign commends this Committee's efforts to explore possible workforce solutions to increasing access to dental care in North Dakota. We strongly support conducting a comprehensive state oral health assessment and translating that data into policy recommendations to meet the needs for your state.

¹ This figure counts children age 1 to 18 eligible for the Early and Periodic Screening, Diagnostic and Treatment Benefit. See U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Annual EPSDT Participation Report, Form CMS-416 (State) Fiscal Year: 2011, April 1, 2013. Analysis by The Pew Charitable Trusts.

² U.S. Department of Health and Human Services, Health Resources and Services Administration, *Designated Health Professional Shortage Areas Statistics*. Data as of October 24, 2013.

³ The American Dental Association: Dental-Related Emergency Department Visits on the Increase in the United States, 2013.

⁴ Center for Health Workforce Studies, School of Public Health, University at Albany, Oral Health in North Dakota: A Background Report, 2012, p. 46.

⁵ \$230,853 represents the total amount paid by Medicaid in 2010, 2011 and 2012 for ER visits with a first-listed ICD-9 code of 521 or 522. North Dakota Department of Human Services, Medical Services Division. Data received by the Pew Charitable Trusts June 6, 2013.

⁶ Centers for Disease Control and Prevention. Accessed October 21, 2013.
<http://www.cdc.gov/fluoridation/statistics/2010stats.htm>

⁷ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2010, 2012,
<http://apps.nccd.cdc.gov/brfss/display.asp?cat=OH&yr=2010&qkey=6610&state=ND>,
<http://apps.nccd.cdc.gov/brfss/display.asp?cat=OH&yr=2012&qkey=8471&state=ND>.

⁸ This figure counts children ages 1 to 18 eligible for the Early and Periodic Screening, Diagnostic and Treatment Benefit. Annual EPSDT Participation Report, Form CMS-416 (State) Fiscal Year: 2011.

⁹ Ibid

¹⁰ Ibid

¹¹ U.S. Department of Health and Human Services, Health Resources and Services Administration, *Find Shortage Areas: HPSA by State & County*. Data as of October 24, 2013.

¹² Center for Health Workforce Studies, School of Public Health, University at Albany, Oral Health in North Dakota: A Background Report, 2012.

¹³ Ibid

¹⁴ Ibid

¹⁵ Institute of Medicine, *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*, 2011 p. 137;

¹⁶ The Children's Partnership; *The Virtual Dental Home: Using new technology to bring dental care to underserved children*, October 2013.