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DENTAL CRISIS IN AMERICA: THE NEED TO ADDRESS COST

HEARING

BEFORE THE

SUBCOMMITTEE ON PRIMARY HEALTH AND AGING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING THE DENTAL CRISIS IN AMERICA, FOCUSING ON THE NEED TO ADDRESS COST

SEPTEMBER 12, 2013

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DENTAL CRISIS IN AMERICA: THE NEED TO ADDRESS COSTS

THURSDAY, SEPTEMBER 12, 2013

U.S. SENATE,
SUBCOMMITTEE ON PRIMARY HEALTH AND AGING,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room SD–430, Dirksen Senate Office Building, Hon. Bernard Sanders, chairman of the subcommittee, presiding.

Present: Senators Sanders, Franken, and Baldwin.

OPENING STATEMENT OF SENATOR SANDERS

Senator SANDERS. The hearing of the U.S. Senate Subcommittee on Primary Health and Aging is going to begin. I want to take this opportunity to thank all of the panelists who are with us today, and I want to thank CSPAN for putting this issue across the country. I also want to thank my colleagues, who I expect will be coming in and out for this hearing.

In the last couple of years, we have had a lot of discussion in our country about a dysfunctional healthcare system in which some 50 million people have no health insurance. We have a crisis in primary care, and despite poor outcomes, we spend almost twice as much per person on healthcare as do the people of many other countries.

Unfortunately, in the midst of the discussion about healthcare in general, we have forgotten and paid very little attention to an element of healthcare that is enormously important to all Americans, and that is dental care and the fact that we have a major crisis in dental care. And I'm glad that CSPAN is here. I'm glad that everybody is here, because this is an issue that needs a whole lot of discussion. It has been kind of pushed under the rug, and it's time that we brought it out into the sunlight.

Last year, I held a hearing on dental care, where we learned that in the United States, we have a major crisis in terms of oral health. Simply put, we learned that people who need dental care the most are the least likely to get it, and that is low- and middle-income Americans, racial or ethnic minorities, pregnant women, seniors, individuals with special needs, and those who live in rural communities.

For example, low-income kids are twice as likely as their higher income peers to develop cavities, and lower income adults are more

than twice as likely as middle and higher income adults to have had all of their teeth removed. And what we know is, all over this country, there are kids who are home today, not going to school because they have serious toothaches. We know that this is a major problem that we are neglecting.

What we also found is that in America today, millions and millions of people live in towns and cities where it is difficult to access dental care. Even if they might have some insurance, they can't find a dentist who will treat them.

We learned that about 17 million low-income children received no dental care in 2009. We learned that—and this is a mind-blowing statistic—one-fourth of adults in the United States ages 65 or older have lost all of their teeth. What about that?

We learned that low-income adults are almost twice as likely as higher income adults to have gone without a dental checkup in the previous year. We learned that bad dental health impacts overall health and increases the risk for diabetes, heart disease, and poor birth outcomes. We learned that there were over 830,000 visits to emergency rooms across the country for preventable dental conditions in 2009, a 16 percent increase over 2006.

In other words, when people are in agony, their only alternative is to go into an emergency room, which, by the way, is very expensive. The people in the emergency room are not trained to deal with the dental problems. They deal with pain relief. And that's how we are spending money on dental care.

We learned that almost 60 percent of kids age 5 to 17 have cavities, making tooth decay five times more common than asthma among children of this age. We learned that nearly 9,500 new dental providers are needed to meet the country's current oral health needs. However, there are more dentists retiring each year than there are dental school graduates to replace them.

The dental crisis not only has high economic and financial costs to individuals in our country, but it comes with high social costs as well. Over $100 billion is spent every year on dental services in the United States. Over a third of these expenditures are paid out-of-pocket. Dental out-of-pocket spending is second to spending on prescription drugs.

In addition to the billions that are spent, billions are lost in missed school days and lost economic opportunity and productivity due to dental pain. Tragically, sometimes people become extremely ill because of oral infections, and, on occasion, people die because they don't get the dental care they need.

So let me be very clear. We are paying for this dental crisis now in an inefficient, ineffective, and unjust dental system where we spend money on those who come to our hospital emergency rooms suffering in pain. And yet we refuse to provide for people to get the care they need before it's too late. I believe that making sure that people can get to the dentist when they need to will prevent not only a lot of suffering, but at the end of the day, saves our country money as well.

Interestingly enough, last year, I asked the people of Vermont and people all over the country to send me their stories about dental access problems. We were just blown away by the kind of response that we got. We had 1,200 responses. I think people are

never asked to talk about it. What we heard was people who are in pain, who can't find a dentist, who worry about their kids. It was really quite something.

I think we have a real problem that needs to be discussed. When we talk, by the way, about the concept of insurance, we usually mean that insurance covers the need. But I think most people understand that dental insurance often pays for a relatively small percentage of one's needs. The average benefit cap is just about $1,500 a year, and, as everybody knows, dental care is extremely expensive.

I hope today our panel will help us to understand why dental care is so very expensive. If you have some serious dental problems, $1,500 is not going to do it. Despite these limits, people with dental insurance are far more likely to see a dentist than those who have no coverage at all. More than one out of every four Americans does not have any dental insurance.

Traditional Medicare—and I see this every day. I don't know, Senator Baldwin, if you run into this as well. But seniors often come up to us and say, "Why is Medicare not covering dental services?" And it certainly does not.

I am chairman of the Senate Committee on Veterans Affairs, and I can tell you that right now—and this is an issue we're working on—the VA does not cover dental care, except for service-connected problems, for our veterans. And States can choose whether their Medicaid programs provide coverage for dental care for lower income adults. Some do a good job. Many do not, which means that low-income Americans with Medicaid in nearly half of the States have no dental benefits or can receive services only in the case of a dental emergency.

To my mind, it is unacceptable, but in our country, millions of people cannot get the care they need to live healthy lives. Dental problems, although entirely preventable, can lead to extreme pain.

Another issue is the stigma of missing teeth. If I'm looking for a job, and I don't have my front teeth, what do you think my potential employer is going to say? He would say, "Actually, you're not the guy we want right here." So when you have no teeth in your mouth, it's like a P on your forehead, saying, "This is a poor person. This is a person we don't want in our workplace." That's an issue that we have to address as well.

The lack of access to dental care and the high cost of dental care are national problems. But as is often the case, the problems are far more acute for lower income Americans. For many people with Medicaid, for example, it is almost impossible to find a dentist who will see them.

Medicaid is inadequate, but even if you do have Medicaid, it is, in many cases, impossible to find a dentist who will serve you. Only 20 percent of dentists accept Medicaid, and only a small percentage of dentists dedicate a significant portion of their practice for the underserved.

When I ask about the high cost of dental care, I am often reminded that most dentists work in small private practices where the overhead is high, and dental school is extremely expensive. That is another very important issue that I hope we can touch

upon, the outrageously expensive cost of dental school, people graduating with hundreds of thousands of dollars in debt.

But in a report released today, just today, the Government Accountability Office, the GAO, found wide variations in fees charged by dentists. For eight of 24 common procedures the GAO examined, those charging at the high end charge more than double what those with average fees charge their patients. That's a whole other issue, why the cost of dental care is so expensive and the discrepancy in prices that we see all over the country.

There is some good news out there, and we're going to hear some good news today. The good news is that we are making progress in expanding the number of locations where lower income people and working people can get access to dental care. FQHCs, Federally Qualified Health Centers, provide dental services to more than 4 million Americans across the country, regardless of their ability to pay.

Under the Affordable Care Act, I and others worked very, very hard to expand FQHCs to the tune of some $12 billion or $13 billion and to put money into the National Health Service Corps so that we can help dentists get their student debts paid by the government so they can work in underserved areas.

More than 90 percent of those that receive care at FQHCs have incomes that are 200 percent or below the Federal poverty line. I know in Vermont, we are having some success. We have about 25,000 people getting their dental care now through FQHCs.

We have established school clinics, and they are working really well in at least two locations where there's a beautiful dental clinic right in the school. Kids are coming in. In some cases, adults are coming in. That's a concept that I like very much, and maybe we can talk about that.

Later this month, I intend to reintroduce the Comprehensive Dental Reform Act. This bill addresses the dental crisis in America by expanding coverage to people with Medicare, Medicaid, veterans health benefits, and the Affordable Care Act to significantly increase the number of people with insurance, expanding the number of places where people can seek care, enhancing the workforce, and improving education to respond to the needs of the underserved.

While this bill will, in fact, cost money—it is an expensive bill—it is worth repeating that we're already paying huge sums for dental care through emergency room visits, hospital stays, and lost wages and productivity. The bottom line is we have a crisis in this country in terms of dental care. We are wasting huge amounts of money, and it is time to make sure that every American gets the dental care he or she needs and to make sure that we especially take care of our kids.

Senator Baldwin, I understand that you're going to have to be leaving us soon and you wanted to make an introduction of one of our panelists.

STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. If I could make an opening statement and then——

Senator SANDERS. Sure.

Senator BALDWIN. I can stay for a little while.

Senator SANDERS. Great. Great to have you.

Senator BALDWIN. So we can do it in the regular order you planned, Mr. Chairman.

I want to thank you, Mr. Chairman, for holding this very, very important hearing.

I appreciate the chairman's longstanding commitment to extending quality affordable dental care to all Americans. Far too many Americans do not have access to dental care. One of my constituents recently wrote to me and said that American dental care is unfortunately stratified into two buckets, the haves and the have nots. For those who currently lack access, the have nots, we must promote policy to expand coverage, including investing in Federally Qualified Health Centers.

I'm pleased to have Mr. Greg Nycz here from the Family Health Center of Marshfield, WI. Mr. Nycz's center has been instrumental in expanding dental care to vulnerable populations in rural areas and tribal areas in the State of Wisconsin. He will shortly be offering some keen insight on the benefits of the health center model.

For the haves, those Americans who currently have access to dental care, that care has grown significantly more expensive over recent years, putting a lot of stress on middle-class families' budgets. We have to do all that we can to address these increasing costs, because they ultimately threaten public health and economic security.

But major opportunities exist at this moment. As we move forward with reforms to our underlying healthcare system, reforms that focus on delivering healthcare of higher quality at a lower cost, dental care must be an integral part of those changes and those reforms.

First, ensuring access to dental care must be a major component of investing in preventative services so that we can save costs later by helping people avoid developing chronic diseases. Second, dental care should become more integrated into healthcare models. We need to tear down those artificial barriers that exist between dental and medical. They are artificial barriers. By delivering more integrated care, we will decrease cost and improve the quality of care.

I look forward, Mr. Chairman, to the testimony of today's panel. I can remain a little longer and would love the opportunity to introduce my constituent when that moment arrives.

Senator SANDERS. Thank you very much, Senator Baldwin, for your hard work on this issue.

Let me now take the opportunity to introduce our panelists. Our first witness is Dr. Frank Catalanotto.

Dr. Catalanotto is a dentist and a professor and chair of the Department of Community Dentistry and Behavioral Science at the University of Florida College of Dentistry in Gainesville. He is also vice chair of the board of directors of Oral Health America.

Senator Baldwin, do you want to introduce Mr. Nycz?

Senator BALDWIN. Thank you, Mr. Chairman. It is my great pleasure to introduce Mr. Greg Nycz. Mr. Nycz is the director of the Family Health Center of Marshfield, WI, which is a Federally Qualified Health Center. Mr. Nycz has been involved with the

planning and operation of the Family Health Center for over 40 years.

The Family Health Center of Marshfield is one of the largest FQHC dental practices in the Nation and the largest provider of dental services to Medicaid patients in the State of Wisconsin. I have always admired the work that the Family Health Center has done to increase access to care in my home State.

Mr. Nycz, I will look forward to your testimony today.

As you noted, Mr. Chairman, unfortunately, I'm going to have to leave midway through the testimony.

But thank you so much for being here.

Senator SANDERS. Thank you.

Our next panelist will be Cathi Stallings. Ms. Stallings is a social worker from Falls Church, VA, who has seen firsthand both personally, as I understand it, and professionally, the need to increase access to affordable dental care. She received her master's in social work from Virginia Commonwealth University.

We thank you for being with us.

Our final witness is Dr. Debony Hughes. Dr. Hughes has worked at the Prince George's County Health Department for 17 years and has served as the Program Chief of Dental Health there since 2007. In this role, she oversees the Deamonte Driver Dental Project. She also serves on the Maryland Dental Action Coalition Board. She began her public health career as a dentist in Bristol, VT. But she left us.

[Laughter.]

Again, I want to thank all of you for being here. What we are trying to do and what this hearing is about is to focus attention on a crisis which does not get the discussion that it needs. It's going to be a long, hard fight, but that's what we're trying to do.

Dr. Catalanotto, thank you for being here. Please make your presentation.

STATEMENT OF FRANK A. CATALANOTTO, DMD, PROFESSOR AND CHAIR, DEPARTMENT OF COMMUNITY DENTISTRY AND BEHAVIORAL SCIENCE, UNIVERSITY OF FLORIDA COLLEGE OF DENTISTRY, AND VICE CHAIR OF THE BOARD OF DIRECTORS, ORAL HEALTH AMERICA, GAINESVILLE, FL

Mr. CATALANOTTO. Mr. Chairman, members of the subcommittee, thank you very much for the opportunity to talk about access to oral healthcare. My name is Frank Catalanotto, and I've spent almost 40 years in dental education but for the last 20 years have been advocating for a better way to deliver oral healthcare.

There are several indicators about this access problem that I'd like to mention. First, dental care utilization has declined about 10 percent in the last decade among low-income people, primarily for cost.

Second, we have made some good progress in the last decade to improve access to care for children. But we still have approximately 60 percent of Medicaid enrolled children who are not receiving proven, cost-effective, and preventive dental services. And, third, as the Senator said, hospital emergency room visits for dental problems have increased 16 percent to over 830,000 visits in 2009, a very significant wasted cost.

What are the effects of this lack of access to care? Two examples: First, children who miss school because of dental problems do less well in school than other children. Education is the way out of poverty, but children in pain cannot learn.

Second, a recent study from 2000 to 2008 showed that 61,000 patients across the country were hospitalized for a preventable dental infection. And Deamonte Driver was not an isolated example. Sixty-six deaths were reported in this study at an estimated cost of $840 million. This is not a personal tragedy only. This is an economic loss.

Let me mention dental schools. Dental schools are an important part of the dental safety net, with faculty and students that actually do provide care outside of the dental school in community-based settings accessible to the underserved. But dental education is very lengthy and expensive. That makes dentists a very expensive part of the healthcare team.

The 165,000-plus dentists in the United States provide high quality dental care to those patients who can afford their services. Unfortunately, many of these dentists do not participate in the Medicaid program. There are many reasons for this, including low reimbursement rates. But no matter the reason, this significantly reduces access for many patients.

Dentists provide significant pro bono care. However, I would remind you that while philanthropic care is wonderful, philanthropy is not a healthcare system and does little for long-term oral health care.

Another concern I have and others have is that there are restrictive State dental practice acts that do very little to actually protect the health of the public and can specifically impede improving access to oral healthcare. I'll give two specific examples in a minute.

What are some of the potential solutions to this access problem? I will only focus on workforce, although there are many others. A new dental workforce model, at least new to the United States, is the dental therapist.

These therapists are members of the oral healthcare team who provide preventive and limited restorative care to their patients. They have been employed in over 50 countries for over 90 years. They come from the ethnically and economically diverse communities they go back to serve.

They are inexpensive to educate. They are cost-effective to hire. They are safe practitioners, no matter what else you may hear. They are currently employed in Alaska and Minnesota. There are at least 15 other States working to include them, but they are being blocked by restrictive dental practice acts at the State level and by the American Dental Association at the national level.

Second, a more cost-effective location for delivering dental care is in a large group practice setting that employs multiple dentists and thus has lower overhead than the traditional dentist-owned single dental practices, thus reducing cost. One example you'll hear about in a minute. But another example is the not-for-profit Sarrell Dental Centers of Alabama that provide excellent comprehensive care. In the past 8 years, they have grown from 15 sites to nearly 500,000, using a combination of a culture of caring, evidence-based

practice, innovative business practices, marketing, and community outreach.

Let me leave you with this last sentence, what Sarrell has done. They have reduced cost to the Medicaid program from an average annual cost in 2005 of $328 to $125 in 2012. This is a remarkable business model that takes care of patients.

We need more of these around the country. We can't, because there are some States that have a restrictive dental practice act that will not allow a business like Sarrell to be owned by a non-dentist. This is ludicrous when the major hospitals in this country are run by MBAs.

In closing, I'd like to point out that Congress is lobbied by many members of the dental industry, including dental academics. But who lobbies for the patient for increased access to care, for oral health services that prevent pain and suffering, for increased ability to learn and work, and for lower cost? I would suggest that we need you in your leadership roles in Congress to fight for those patients.

Thank you very much, Senator.

[The prepared statement of Mr. Catalanotto follows:]

PREPARED STATEMENT OF FRANK A. CATALANOTTO, DMD

Mr. Chairman, members of the subcommittee, thank you very much for the opportunity to speak with you this morning about access to oral health care in the United States. My name is Dr. Frank Catalanotto. I am a children's dentist who has spent almost 40 years in dental education and for the last 20 years, advocating for a better way to deliver oral health care. I am currently the Chair of the Department of Community Dentistry at the University of Florida College of Dentistry. I am here this morning to ask your assistance in improving access to oral health care in the United States.

1. CHALLENGES FACING THE UNITED STATES RELATED TO ORAL HEALTH CARE

There are several indicators I can share with you that clearly illustrate the lack of access to oral health care in this country. First, Dental Care Utilization has declined among low-income adults over the past decade (ADA Health Policy Resource Center); over 35 percent of low-income seniors have not seen a dentist in over 4 years, primarily because of costs. Second, while we have made significant progress in improving access to care for children, there are about 48 percent of Medicaid enrolled children who are not receiving preventive dental services and about 77 percent of these children are not receiving restorative services. Third, according to a study released by the PEW Children's Dental Campaign in 2012, the number of Americans who have gone to hospital emergency rooms for dental pain and infections has increased 16 percent from 2006 to 2009; this included over 830,000 such dental visits. Hospital dental emergency rooms are very expensive—in Florida in 2010, there were over 115,000 such visits costing over $88 million, and they are very inefficient since for most visits, the physicians prescribe antibiotics and pain medication and suggest the patient see a dentist the next day, something these patients cannot afford.

What are the effects of this lack of access to oral health care?—A number of recent scientific reports, some by United Concordia Insurance, have shown that preventive dental care can reduce overall medical care costs for patients with diabetes and heart disease. Imagine if these benefits could be extended to the entire population and how that might help reduce overall health care costs in the United States. Second, several studies have now shown that children who missed school because of dental problems did less well in school than children who missed school for other reasons. Education is a way out of poverty, thus, to me; there is a clear economic advantage to having improved access to dental care. Third, a recently published study showed that over a 9-year period from 2000–8, a total of 61,439 patients were hospitalized because of a dental infection. More important, a total of 66 patients died during these hospitalizations, all for lack of access to quality preventive dental care. This is a personal tragedy, not just an economic loss.

2. THE ROLE OF DENTAL EDUCATION IN ADDRESSING LACK OF ACCESS

Dental schools educate a highly competent workforce and conduct research to address the oral health needs of our county. Congress has recognized the importance of dental schools and funds HRSA to provide grants to support modernizing and reshaping dental education to meet the changing needs of the oral health workforce with a particular focus on health care disparities. Our team actually has several of these grants at the University of Florida and for that I am grateful. For example, dental schools across the country are working hard to recruit a dentist workforce that better mirrors the racial and economic diversity of our country. Dental schools are an important part of the dental safety net, providing much care in community-based settings such as federally Qualified Health Centers. But I would also add that dental education is very expensive, making dentists a very expensive part of the oral health care team.

3. THE ROLE OF THE PRACTICING DENTIST AND THE AMERICAN DENTAL ASSOCIATION

The 100,000 plus dentists in the United States provide high quality dental care to a large number of patients. Unfortunately, many of these same dentists do not participate in the Medicaid program; for example, in Florida, only about 12 percent of dentists see Medicaid patients. There are many reasons for this including low reimbursement rates and the very high overhead of dental practice making it somewhat cost-inefficient, but, no matter the reason, this significantly reduces access for many patients.

In addition, these dentists provide significant pro-bono care either in their offices or through such events as Missions of Mercy in which large numbers of dentist convene in a large facility or even tents and patients line up sometimes a day in advance to obtain some limited care. **However, I would submit to you that while philanthropic care is wonderful, philanthropy is not a health care system and does little for long-term oral health.** Another concern is restrictive dental practice acts that do little to help protect the health of the public and can really impede improving access to oral health care. I will give two specific examples at the end of my remarks.

4. WHAT ARE SOME POTENTIAL SOLUTIONS TO THIS ACCESS PROBLEM?

I categorize these potential solutions into three groups including in the accompanying Power Points including dental insurance, patient education and workforce. Because of the limited time, I will only focus my comments on workforce: Bottom Line—we need an oral health workforce that is less expensive than dentists to deliver routine dental services so that dentists can focus on more complex procedures and we need workforce locations that are more efficient and cost-effective than private dental practices with their high overhead.

First, a comment about "The Comprehensive Dental Reform Act of 2013." This legislation extends dental insurance to millions of Americans. A number of other components will really help improve the oral health workforce in ways I will now address in my closing comments. **But thanks for this legislation.**

A new dental workforce model—new to the United States—is the dental therapist. These therapists are members of the oral health care team who can provide preventive limited restorative dental care to patients under the supervision of a dentist. They have been employed in over 50 countries around the world for over 90 years. They are usually recruited from the ethically and economically diverse communities they return back to serve. They are inexpensive to educate and cost-effective to hire. They are safe practitioners, no matter what else you may hear. They are currently employed in the United States in Alaska and Minnesota. There are at least 15 other States who are working to include dental therapists in the workforce but these efforts are being blocked by organized dentistry and the restrictive dental practice acts I mentioned earlier.

Second, a more cost-effective location for delivering dental practices is a large practice setting that employs several dentists and other oral health care providers and thus has a lower overhead than the traditional dentist-owned single dentist practices. The recent Senate Report on Corporate Dentistry has illustrated some concerns about the profit-driven, equity-backed corporate model but there are excellent not-for-profit models such as the Sarrell Dental Centers of Alabama that provide excellent comprehensive preventive oriented care to low-income patients. In the past 8 years, Sarrell has grown to 15 sites providing care to nearly 500,000 Medicaid recipients. Uses a combination of a "Culture of Caring", evidence-based dental practices, innovative business approaches, marketing and community outreach. **Most importantly, they have demonstrated a decline in the average Med-**

icaid reimbursement from $328 in 2005 to $125 in 2012. This is a truly unique model of dental practice. Unfortunately, many State dental practice acts across the country prevent dental practices from being owned and managed by non-dentists, something done across the country by medical groups and hospitals. We could use congressional help in expanding the Sarrell and similar models across the country.

In closing, I would like to point out Congress is lobbied by many members of the dental industry including dentists, dental schools, dental industry, and insurance companies. But who lobbies for the patient for increased access to preventive and therapeutic oral health services that can prevent pain and suffering, increase ability to learn and work, and eventually help lower health care costs. I would suggest that we need you as elected Members of Congress to help these patients. THANK YOU!

UNIVERSITY OF FLORIDA COLLEGE OF DENTISTRY

"DENTAL CRISIS IN AMERICA: THE NEED TO ADDRESS COST"

FRANK A. CATALANOTTO, DMD—WHO AM I?

• Educated as a pediatric dentist, 39-year career in dental education, past president of the American Dental Education Association, former dean at University of Florida, now chair of Department of Community Dentistry and Behavioral Science (Public Health).
• Committed to improving access to oral health for all by education oral health services research, and advocacy.
• Vice chair, board of directors, Oral Health America.
• Chair, Leadership Council, Oral Health Florida.
• Viewpoint expressed this morning is my own and does not necessarily reflect the views of the University of Florida, Oral Health America or Oral Health Florida.

WHAT CAN I COVER IN 5 MINUTES?

• Challenges to U.S. oral health care system.
• Role of Dental Education:
  • educating workforce, and
  • safety net provider.
• Role of the practicing dentist and the American Dental Association—Philanthropic Care, Regulation and Restrictive Dental Practice Acts.
• Consolidation in the dental industry. Role of:
  • corporate/for profit models of dental practice; and
  • large scale not-for-profit models (e.g., Sarrell).
• Potential solutions:
  • insurance,
  • new workforce models, and
  • large, cost-effective not-for-profit dental practices.

CHALLENGES: INDICATORS OF LACK OF ACCESS TO ORAL HEALTH CARE

• Adults not seeking dental care.
• Children doing better but still a serious lack of access and utilization.
• Hospital Emergency Room for dental care is increasing; but hospital ERs do not solve the problem. "Pay me now or pay me later."

WHO ARE THESE PEOPLE WITH DISPARITIES OF ACCESS AND ORAL HEALTH?

The Culture of Poverty

"Many of us have no real understanding of what poverty is. We may be broke most of the time, in debt, unsure of how we'll pay the phone bill. But those particular definitions can apply to middle class. Poverty is something else. Missed meals, a reliance on government aide, homes without power or telephone services—these are the earmarks of the culture of poverty."

• Those in POVERTY, patients on Medicaid, CHIP.
• Racial and Ethnic minorities.
• Traditionally, children, the elderly, rural, single mothers.
• The uninsured, including the working poor.
• Any who do not understand the importance of optimal oral health.
• Increasingly in this recession, lower middle-class and middle-class families. WORKING FAMILIES

Dental Care Utilization Declined Among Low-Income Adults and Increased Among Low-Income Children in Most States From 2000–2010

(ADA Health Policy Resource Center)

	Children			Adults		
	2000	2010	% Change	2000	2010	% Change
U.S. overall	27%	41%	53%	54%	48%	-10%

*Note both still below 50 percent.

ADULT DENTAL CARE

• The decrease in adults seeking dental care cuts across economic groups with reductions in upper income, middle income and 6 percent lower income groups. **REASON—COSTS.**

• Recent HARRIS—Oral Health America Poll. Almost half of older adults with incomes of $35,000 or less have not been to the dentist in 2 years and 35 percent of all lower income older adults have not sought dental care in the last 4 years. **REASON—COSTS**

Table 4: Children Age 1–20 Enrolled in EPSDT for at Least 90 Continuous Days Who Received a Preventive Dental Service, or a Dental Treatment Service in Fiscal Year 2011

REGION	Total children receiving a preventive dental service	Percent Children receiving a preventive dental service	Total children receiving a dental treatment service	Percent Children receiving a dental treatment service
U.S. Overall	13,550,097	42.2	7,466,214	23.3

Source: Fiscal Year 2011, CMS–416 Reports.

A COSTLY DENTAL DESTINATION—HOSPITAL CARE MEANS STATES PAY DEARLY

PEW CHILDRENS DENTAL CAMPAIGN–ISSUE BRIEF 2012

• *Preventable* dental conditions accounted for **830,590 visits to ERs** nationwide in 2009.

• **a 16 percent increase from 2006.**

• Emergency rooms are the first and last resort because their families struggle to find a dentist who either practices in their area or accepts Medicaid patients.

PAY ME NOW OR PAY ME LATER

• Hospital ER visits do not provide "treatment" of the underlying dental problem, only relief of symptoms of pain and infection.

• Hospital ER visits cost money to Medicaid and insurance but for the uninsured, the hospitals usually absorb those costs. In other words, you/we are already paying for dental care for these patients.

• Makes more sense to pay up front for increased access and preventive and restorative dentistry.

• We need insurance and oral health professionals who are willing to work in underserved communities to provide these services to patients who cannot afford traditional dental services.

EFFECTS OF LACK OF ACCESS TO ORAL HEALTH CARE

• Oral Health and overall body health.
• Effects on School Learning in children.
• Morbidity and Mortality.

ORAL HEALTH AND OVERALL BODY HEALTH

• New recently published reports showing **lower annual health care (MEDICAL) costs** for patients with chronic disease processes such as diabetes and heart disease **if these patients have been treated successfully for periodontal disease** and continued to maintain their periodontal health. **The savings noted were significant.**

• Visit the UCH Wellness Oral Health Study on United Concordia Web site to learn more.

Impact of poor oral health on children's school attendance and performance [1]

• Children who missed school days because of dental problems did less well in school than children who missed school for other reasons.

OUTCOMES OF HOSPITALIZATIONS ATTRIBUTED TO PERIAPICAL ABSCESS FROM 2000 TO 2008: A LONGITUDINAL TREND ANALYSIS [2]

During the 9-year study period (2000–8), a total of 61,439 hospitalizations were primarily attributed to dental/tooth infections in the United States. ***A total of 66 patients died in hospitals.***

This is not only a "cost issue," this is a life and death issue!

ROLE OF DENTAL EDUCATION

• Academic Dental Institutions include dental schools and allied dental education programs.
• Educate and train a highly competent workforce and conduct research to address oral health needs of the country.
• Congress via HRSA has been very supportive of need for grants to support modernizing and reshaping dental education to meet changing needs of the oral health workforce with a particular focus on health care disparities.
• Academic Dental Institutions are a very important part of the safety net for underserved patients.
• Using our admissions policies to recruit a workforce that represents the diversity of the United States.
• **University of Florida Statewide Network for Community Oral Health** sends students out to work in community settings such as Federally Qualified Community Health Centers.
• HOWEVER, educating dentists is a very expensive component of the dental workforce.

ROLE OF THE PRACTICING DENTIST AND THE AMERICAN DENTAL ASSOCIATION

• The 100,000-plus dentists in the United States provide high quality care to a large number of patients.
• These dentists provide significant pro-bono care to the underserved in their practices, in philanthropic clinics, and in national events such as Give Kids a Smile days and Missions of Mercy (MOM) events.

DENTISTS AND MEDICAID PATIENTS [3]

• Low Reimbursement* (but increasing rates does not always work).
• Administrative hassles* (this is real).
• Medicaid patients do not keep appointments* (but they can!).
• Do not want to mix Medicaid and other patients in waiting/reception room.*
• Sense of Social Justice.*
• Social Stigma of being a Medicaid provider.**

[1] Jackson SL, Vann WF Jr, Kotch JB, Pahel BT, Lee JY. Am J Public Health. 2011 Oct;101(10):1900–6. doi: 10.2105/AJPH.2010.200915. Epub 2011 Feb 17. PMID: 21330579 [PubMed—indexed for MEDLINE].

[2] J Endod. 2013 Sep;39(9):1104–10. doi: 10.1016/j.joen.2013.04.042. Epub 2013 Jul 11.

[3] (*Published; **in preparation by my team.)

PHILANTHROPY—MISSIONS OF MERCY

While philanthropic care is wonderful, I would submit to you that philanthropic care **is not a health care system** and does little for long-term oral health.

THERE IS A BODY OF LITERATURE ON RESTRICTIVE PRACTICES IN DENTAL LICENSING[4 5 6]

- Purpose of regulation (State dental practice acts) is to safeguard the health of the public and promote competition.
- Substantial literature says this does not occur.
- In fact, the more restrictive the dental practice act, the higher the income of the practitioners and no demonstrable effect on the health of the public.
- Many State dental practice acts forbid a non dentist from owning a dental practice as will be discussed with a not-for-profit model in a few minutes.
- Such restrictive regulation negatively impacts access for the underserved.

POTENTIAL SOLUTIONS

- **Insurance for oral health services**
  - Patients with insurance are healthier than patients without insurance.
- **Educate patients and change their behavior**
  - Evidence-based practices.
  - Culturally competent practitioners.
- **Workforce**
  - More dentists—a very expensive solution.
  - Expanded work settings and reimbursement models for dental hygienists.
  - New workforce settings and business models.
  - New models of oral health care professionals.

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[4] Doyle, Roger, **License to Work,** *Scientific American*, 296:2, February, 2007.

[5] Kleiner, Morris and Kudrle, Robert, **Does Regulation Affect Economic Outcomes? The Case of Dentistry,** *Journal of Law and Economics,* 43:2, 547–82, October 2000.

[6] Freund, Deborah and Shulman, Jay, **Regulation of the Professions: Results from Dentistry,** *Advances in Health Care Economics and Health Services Research*, 5:161–80, 1984.

INSURANCE FOR ORAL HEALTH SERVICES—"THE COMPREHENSIVE DENTAL REFORM ACT OF 2013"

• Extends comprehensive dental health insurance to millions of Americans.
• A number of other components of this bill will really help improve oral health workforce and access to oral health care.

NEW WORKFORCE MODELS—DENTAL THERAPISTS

• **Dental Therapists** are oral health care team members that can provide preventive and limited restorative care to patients under the direct supervision of dentists.
• Over 90 years of evidence in over 50 countries that they are safe and effective oral health care providers.
• Come from the local community, cultural competency.
• Excellent capacity for case management, patient education, restorative and limited surgical care. Inexpensive to educate and hire.
• Recent studies/reports in the United States clearly demonstrate quality, safety and cost effectiveness.
• Currently in use in Alaska and Minnesota. About 15 other States are considering this model of care.
• Being blocked by restrictive dental practice acts and vigorous opposition by organized dentistry.
• Training grants authorized by Congress but appropriations blocked in recent years.
• Native American Tribes in the "lower 48" would like to utilize Dental Therapists but are being blocked by Congress as a result of lobbying by dentists.

WORKFORCE—CORPORATE MODELS

• **Senate Report on Corporate Models of Dental Practice.**
  • Corporate models are on the increase because of the efficiency and cost effectiveness.
  • Have the potential to provide lower cost care and better access to the underserved.
  • Senate report correctly drew attention to some equity-backed corporate models that have a profit motivation to over-treat patients.
  • But we should not overlook the role of large, not-for-profit models that have an excellent track record of care.

SARRELL DENTAL CENTERS OF ALABAMA

A not-for-profit corporate model that works.

• In 8 years, have grown to 15 sites providing care to nearly 500,000 Medicaid recipients.
• Uses a combination of a "Culture of Caring," evidence-based dental practices, innovative business approaches, marketing and community outreach.
• **Demonstrated a decline in the average Medicaid reimbursement from $328 in 2005 to $125 in 2012.**
• So, why not expand this model across the United States?
• Strong opposition from the Alabama Dental Association that was only resolved by legislation and intervention by the FTC.
• Many dental practice acts across the country prevent dental practices from being owned and managed by non-dentists, something done across the country by medical groups and hospitals.

CLOSING AND THANK YOU

• Congress is lobbied by many members of the dental industry including dentists, dental schools, dental industry, insurance companies.
• **But who lobbies for the patient** for increased access to preventive and therapeutic oral health services that can prevent pain and suffering, increase ability to learn and work, and eventually help lower health care costs.
• I would suggest that **we need you as elected Members of Congress** to help us as patients.

Senator SANDERS. Thank you very much.
Mr. Nycz.

STATEMENT OF GREG NYCZ, EXECUTIVE DIRECTOR, FAMILY HEALTH CENTER OF MARSHFIELD, INC., MARSHFIELD, WI

Mr. NYCZ. Good morning, Senator Sanders.

And thanks for the kind introduction, Senator Baldwin.

I want to thank the subcommittee for the opportunity to testify today on a topic I am passionate about, the need to improve access to dental care in our country.

I'm here representing Family Health Center of Marshfield, the center that serves a large region in Wisconsin approximately the size of the State of Maryland. About a third of our residents are poor or near poor.

Twenty years ago, I served on the Wisconsin Dental Association's Access to Care Committee as their only non-dentist. In that role, my phone number was listed as a resource for people seeking dental care. I took many calls.

One day, I picked up the phone, and it was a young mother, failing to hold back the tears as her child screamed in pain and sobbed uncontrollably. The mother broke down. She had been trying for days, calling over 30 dental offices for help, someone who would stop her child's pain.

Such conversations were not uncommon for me back then. But what made this conversation a life changer for me was that I came to realize as I spoke with her that she was not just bearing the burden of her child's pain, but also the self-imposed pain that came with her conclusion that she was a failure as a mother.

I'm proud of Wisconsin, and I'm proud of my country. But none of what that mother was enduring had to be, because it was all preventable, and there's really no mystery associated with how to fix it.

After a decade of frustration, trying to improve the system and using traditional routes, my board said, "Find another way. This is your top priority." Ten years later—and I brought a picture to show this—we've served nearly 100,000 folks. Even we were surprised by the enormous response.

Our patient origin map shows that in spite of the fact that we are located in northern Wisconsin, we've seen State residents from every county and 73 percent of our State's zip codes. Our patients tell us where we are needed.

When we established our Park Falls clinic, over 1,000 people traveled over 412,000 miles to get care with us at Park Falls, mostly from the Rhinelander area. Today, we have a clinic in Rhinelander as a result of that.

The folks who lacked access, the elderly, those on Medicaid, and the uninsured poor, we knew about. But what surprised us was that veterans with limited incomes could not get care. Today, they now have a place to go.

Those who journey the farthest are disproportionately people of all ages who have emergency dental needs and caregivers who bring their developmentally disabled loved ones for care at our sites—another group that is left behind.

Recall the quote from Alice in Wonderland, "If you don't know where you're going, any road will get you there." We knew to get to our preferred future, we would need societal investment. So we

have been relentless in looking for ways to maximize the value of our efforts for the taxpayer, not just the patients we serve.

We learned that we could improve the performance of our job placement agencies by making job seekers with horrible oral decay more presentable and employable. One of our counties with about 34,000 in population told us that they have about 100 such adults every year.

We learned that annual savings on the medical care side possibly in the range of $2,000 to $3,000 are possible for patients with diabetes if we give them proper dental care. And we learned we could be a real alternative to the emergency room and the hospital by opening our doors to patients with dental emergencies from across the State.

I would like to leave you with three thoughts. First, success will require that we fundamentally work to change our Nation's perspective on the importance of oral health in its own right and the added value oral health brings to general health.

Second, workforce matters. Over the next 20 years, Wisconsin may face 2.2 dentists retiring for each new dentist entering practice. And new graduates need to be better prepared to face more elderly patients with complex multiple medical conditions.

Third and perhaps most importantly, at the community level, we are seeking to accomplish this by pursuing an integrative medical-dental model that leaves no one behind. This is the missions of all health centers. We are solving healthcare access problems one community at a time, and we're in 9,000 communities.

But the current demand for care is outpacing our growth. Over 300 of us applied for funding to meet unidentified unmet dental needs in 2011. Unfortunately, a last minute budget deal cut $600 million from planned health center funding, and there have been no opportunities to fund oral health expansion since then.

Our Nation's health centers are your health centers. The health center model has what it takes to solve the oral health disparity problems for a growing number of our Nation's communities. And I appreciate Congress' past support of health centers and ask that you continue to invest in our Nation's health centers. Give us more work, for there is more work to be done.

Thank you.

[The prepared statement of Mr. Nycz follows:]

PREPARED STATEMENT OF GREG NYCZ

Good morning Chairman Sanders, Ranking Member Burr, and distinguished members of the Subcommittee on Primary Health and Aging. My name is Greg Nycz and I want to thank you for the opportunity to testify today before the subcommittee. I am the executive director of Family Health Center of Marshfield, Inc. a federally and State-supported community health center. Our Center serves a 10,354-square mile rural area in northern Wisconsin with 403,964 residents, 125,229 of which have incomes at or below 200 percent of poverty. I greatly appreciate the opportunity you've extended to me to share insights accumulated over the last 20 years working with organized dentistry and then building our own dental capacity in an effort to assist our State in resolving significant oral health access problems for many of our residents.

For most of the decade of the 1990s, I worked for change within organized dentistry in Wisconsin. The Wisconsin Dental Association, keenly aware of the access problems in the State's Medicaid program, convened a committee to explore ways to resolve access problems and enable more of our State's dentists to participate in the Medicaid program. They extended an invitation to me to serve on that com-

mittee as the only non-dentist in order to get the perspective of a community health center director. At the time, there was no lack of passion or commitment from the committee members. Wisconsin's Medicaid office staff were most helpful in streamlining some of the administrative impediments to greater dentist participation, and during the time of my tenure on the committee we were successful in obtaining an increase in State Medicaid rates. However, in spite of all these efforts, problems persisted and, following passage of the State Child Health Improvement Act and an annual stagnation in dental payment rates, access problems grew worse.

In September 2001, shortly after the Surgeon General's report on the oral health of the Nation, my board faced the prospect of continued deterioration in access to oral health services for our Medicaid and uninsured patients. They directed staff to prioritize solving the oral health access and disparity problems throughout our extensive rural service area. As staff set about the task of fixing the system, we studied the problems more closely, which eventually led us to a question. How do we solve a problem that is pervasive at the State and national level? From a health center perspective the answer to this question is one community at a time. So that is what we set about doing. Our State welcomed our involvement as did our major partner, Marshfield Clinic. An expanded State rural dental clinic grant program provided us with resources to build our first dental center in 2003.

Family Health Center has had a long-term partnership with Marshfield Clinic, relying on, rather than duplicating some of its core infrastructure. While Marshfield Clinic is a large regionalized health system with most specialties in medicine represented, they like many other health systems lacked any dental health professionals. Given their size, reputation, and our desire to promote the integration of dentistry and medicine, Family Health Center approached Marshfield Clinic to partner with us on our dental initiative. We provided them with information on what amounted to a public health crisis in Wisconsin affecting many Clinic and Family Health Center patients, and suggested that together we could have a much larger impact on the problem throughout our collective service area than our organization could do on its own. Recognizing the scope of the problem, Marshfield Clinic leadership unanimously voted to lend its infrastructure and later additional funding in support of our initiative to reduce oral health disparities throughout the region. This Marshfield Clinic decision enabled the rapid expansion of our dental system which by October 1, 2013, will also include a 9th dental clinic on Ho-Chunk Nation land near Black River Falls, WI.

Because of State taxpayer investment in our program and also because of strong evidence that literally tens of thousands of Wisconsin residents were going to emergency rooms every year for treatment of non-traumatic dental pain, we committed to caring for patients with emergency dental conditions from across the State. Figure 1 demonstrates that from the provision of our first dental service in temporary facilities in November 2002 through June 2013 we have cared for 95,535 unique patients. Strikingly, they have come from every one of Wisconsin's counties and from 73 percent of its zip code areas. We have treated patients from Wisconsin's largest cities who traveled, in some cases hundreds of miles, to get to a dental center in communities as small as Neillsville with a population of 2,443. Patient origin maps, like that of Figure 1, both illustrate the breadth and scope of the dental access problem in Wisconsin as well as provide us with information about communities in need. In essence, the underserved population's care seeking patterns inform us where we should consider placing our next dental center.

To illustrate this point, we observed that within the first 15 months of opening our Park Falls dental center, 1,000 patients had driven an estimated 412,000 miles to receive their dental care there from us. Many of these patients were traveling from the community of Rhinelander, which is 67 miles from Park Falls. We investigated this pattern with Rhinelander community leaders, including the mayor, and learned we were only seeing the tip of the iceberg as many people in need couldn't make the trip. A few years later we were able to open our 8th dental center in Rhinelander bringing quality dental services closer to many of our patients and offering an opportunity for dental care to many others who previously couldn't make the trip.

Our progress, and that of my health center colleagues in Wisconsin, has been spurred on by increased investment of State resources in the State rural dental clinic program, and through a doubling of our State's community health center grant. Our State grant focuses on supporting the mission of all of Wisconsin's 17 community health centers. This investment has paid huge dividends for State residents through greatly expanded access to dental care as shown in Figures 2 and 3, which mark the progress and growth of Wisconsin's community health center dental facilities, patients served, and patient visits.

The dramatic progress of Wisconsin's health centers in expanding oral health access to a growing number of Wisconsin residents is echoed in the steady progress health centers across the Nation have made in both incorporating oral health services into their programming and increasing the proportion of their patients who receive oral health services. In 2011, 78 percent of community health centers offered dental services at at least one site. This compares to Healthy People 2020's baseline of 75 percent from 2007 with a nationally established target of 83 percent by 2020. The number of patients receiving dental services at health centers grew from 1.4 million in 2001 to over 4.0 million in 2011, a 186 percent increase. Although this represented 20 percent of total health center patients, more work remains to be done to meet the national goal of 33.3 percent of such patients by 2020. There is robust evidence that health centers stand ready to do this work as reflected in the fact that more than 300 health centers applied for funding to meet identified unmet dental needs in 2011. Unfortunately, a last minute budget deal to keep the Federal Government running that year included a $600 million cut to planned health center funding. As a result, none of the 300 applications were funded. Since then, there have been no subsequent Federal funding opportunities for dental expansion for health centers due to limited appropriations. Indeed, there have been no funding opportunities period for existing health centers to expand their services since the Recovery Act. While this was disappointing, our resolve is strong. The health center community is ready, willing and able to leverage investments from our States and Congress to meet State and national goals. Our integrative approach to health care can create offsetting savings by substituting quality dental services for more expensive emergency room and/or hospital-based treatments that now result from current access barriers. As the rest of my testimony will demonstrate, our approach can also improve health and indeed, save lives.

As the preface to the Surgeon General's report stated,

> "those who suffer the worst oral health are found among the poor of all ages with poor children and poor older Americans particularly vulnerable . . . Individuals who are medically compromised or who have disabilities are at greater risk for oral diseases and in turn oral diseases further jeopardize their health."

Our early experience confirmed the wisdom of this statement. At our ribbon cutting for our second dental center I read a short email to those in attendance. The author of the email reported things were going well, that they were grateful there was a dental clinic that would take their residents, and they were working on arrangements to send us some more patients. What made this short email remarkable was that the author was making arrangements to send his developmentally disabled residents to our dental center, which was 183 miles away.

We quickly learned that accessing dental services for those with significant developmental or cognitive disabilities was even more difficult than the barriers faced by many low-income uninsured or publicly insured residents. Understanding the difficulties many disabled residents face in obtaining oral health services in our State, we entered into a Memorandum of Agreement with our State that in essence said "we are open to and welcome the State's disabled population." Beginning with our second dental center, each dental center has been equipped with large treatment rooms and a wheelchair lift to help accommodate this high need population.

We learned other lessons that surprised us. Local county Veteran's Affairs officers informed us that low-income vets uninsured for dental care had great difficulty accessing care. We learned that VA benefits extended to those who are 100 percent service disabled and that a State program provided some help, but many dentists did not participate in the program because of paperwork issues. We learned that one of the largest constituent complaints voiced to local legislative offices was the inability to get dental care, and we learned that many elderly were foregoing care because of its cost. When we build a dental center and open our doors, our local legislators report that the phones fall silent regarding complaints on access to dental care. Our vets, the disabled, and the poor of all ages have a place to go. Access to dental care is no longer the issue it once was. The health center model leaves no one behind.

It is our belief that any organization that accepts Federal or State taxpayer funds has a huge stewardship responsibility and a requirement to be accountable for the expenditure of funds. One of the ways we try to be accountable is to look for targets of opportunity to add value. To avoid increased emergency room use for non-traumatic oral pain, we work in many emergency patients from all over the State on a daily basis at all of our dental centers. We also believe one of the best services we can provide to our State is to assist our patients in leaving the Medicaid program altogether through job attainment or job promotion. To achieve this goal we accept referrals of job seekers from job placement agencies. Many individuals being

retrained for predominantly service sector jobs have a difficult time getting hired or promoted if they have significant oral health problems. We eagerly accept such referrals in the hope that we increase such individuals' opportunities to achieve gainful employment or promotion and leave Medicaid in favor of private employment-based insurance. In addition we have historically prioritized low-income pregnant women. The reason for this is evidence that periodontal disease may contribute to poorer birth outcomes. While the scientific community is still debating this topic, for the sake of these unborn children, we prefer to do everything possible that might help lead to a better birth outcome.

We have made demonstrable progress. As Figure 4 shows, while Wisconsin was second to last in 2008 among all States in children on Medicaid who received a dental service, the three counties with our dental centers had access rates equivalent to those in the Nation's top performing States. Unfortunately we are far from declaring victory. Our accountabilities to our supporters, including taxpayers and the communities we serve, demand that we do more to generate societal savings to help offset the cost of dental care to those who previously went without that care. What are our options to do better?

There is a tremendous prevention potential in dentistry. We believe there is also a tremendous potential to improve health and reduce costs overall if we can bridge the chasm that exists between medicine and dentistry. We believe the bridge is through closer integration of medicine and dentistry using 21st century technology that can support virtual teaming between our health professionals and their staffs, and through practice changes that reinforce shared professional interests in patients and their health. We have begun acting on these beliefs and received support from like-minded partners. To this end I wish to acknowledge the significant support we have received from Delta Dental of Wisconsin in helping us create an integrated medical/dental electronic record to provide a platform to allow virtual teaming on patients. Delta Dental of Wisconsin has also provided support for oral health research and education initiatives at Marshfield Clinic's Education and Research Divisions. I also wish to acknowledge the DentaQuest Foundation for their support in helping us learn about best practices for engaging our patients with diabetes and encouraging them to seek regular dental care.

We have come to the conclusion that to get to a preferred future we have to fundamentally change how we view dentistry within the larger health care system. To illustrate this point, let's consider a series of questions involving dermatology, a specialty that deals with problems of the skin:

> Why do we think we can afford adult dermatology in our Nation's Medicaid program but not adult dental? Why is it that we don't have separate dermatology insurance like we do for dental insurance? Why is it that we include dermatological care in our medical records but not dental care? Why do most medical care systems, many who tout most if not all medical specialties, exclude dentistry? Why do medical schools teach our future physicians to be concerned about infections anywhere in the body but the oral cavity? Why in Wisconsin, in spite of very low payment rates to physicians and dentists, do most physicians continue to treat Medicaid patients while most dentists do not?

Other policy-oriented examples are the exclusion of dental benefits in Medicare and the limitations on dental benefits in the VA. A more recent example is the promotion of "primary care medical homes" a terminology that excludes dental. Why not "primary care health homes" which is a much more inclusive concept? (Incidentally, most federally qualified health centers would rightly consider themselves to be integrated primary care health homes). The separate and stark contrast between dentistry and medicine beginning with training and continuing through insurance and practice policies should increasingly be questioned in light of a growing body of scientific evidence linking oral and systemic health.[1]

Everyone is united in wanting our country to derive even more value from our health care system, with better quality at a lower price point. If that is the case, then why is there such reluctance to act? We can debate whether we can afford to have dental benefits covered under our Medicare program or whether all States should offer dental benefits to adults in their Medicaid programs. But if cost is the central issue holding us back, if cost is the driver in much of our decisionmaking, why don't we act to lower costs when an evidence-base outlining on how it could be done exists? Consider the following. As a nation we fund medical research through the National Institutes of Health. That societal investment has helped us understand that connections exist between diabetes and periodontal disease and to

[1] Powell V, Din F, Acharya A, et al., Project on Clinical Data Integration Page 20, Contact points between medical and dental care/research—Version J: Categories (1–29) and references).

treat one without treating the other does have health and cost consequences. (Please refer to Attachment 1 for a concise summary of some evidence regarding periodontal disease and diabetes.) The value of our investment in research to our Nation's taxpayers is magnified when we put the results of that research into practice.

The private sector has responded and is attempting to leverage this knowledge: the public sector should as well. What seems to have driven the private sector to act was the emerging evidence, mostly from the past 10 years, that individuals with selected chronic health conditions or combinations of them benefit from improved oral health, specifically improved periodontal status, and that potentially large reductions in medical care costs associated with their chronic condition(s) follow closely and appear to be sustainable as long as good oral health is maintained. The emerging evidence appears strongest for individuals with diabetes (only) or in combination with cardiovascular disease, kidney disease or congestive heart failure. Savings of approximately 10 percent annually for individuals with diabetes receiving periodontal care were reported in a multi-year Michigan Blue Cross Blue Shield study. That study also found annual medical cost reductions ranging from 20–40 percent for individuals with diabetes and at least one other chronic condition previously noted.[2]

A 2006–8 CIGNA study of 46,094 individuals with diabetes estimated annual medical cost savings of $2,483/person (23 percent) in year 3 for those who received dental care. Notably, study results suggested increasing annual cost savings as a function of continuing better oral health among those individuals with diabetes that received periodontal care at baseline (2006) and continued maintenance oral health care annually compared to those individuals that did neither.[3]

United Concordia and Highmark, Inc. reported average medical care cost savings of $1,814 per year over 3 years for individuals with diabetes who sought periodontal treatment and subsequent regular dental care during the 2007–9 study compared to individuals with diabetes who did not receive dental care during the study period. Another important study result was additional estimated cost savings of $1,477 per person per year among individuals with diabetes after they completed seven periodontal treatments and/or oral health maintenance visits. In subsequent analyses that examined the relationships between gum disease and other medical conditions, annual medical cost savings from reduced hospitalization and office visits associated with periodontal treatment were found for heart disease ($2,956), cerebrovascular disease ($1,029), rheumatoid arthritis ($3,964) and pregnancy ($2,430).[4]

A recent study in an HMO population provides further insight into the potential sources of savings associated with better oral health status among individuals with diabetes. Diabetes-specific hospital emergency department visits rates were more than 60 percent higher (16.2 percent vs. 10.1 percent) and diabetes-related hospitalization rates were more than 75 percent higher (14.8 percent vs. 8.3 percent) among individuals with diabetes who did not seek dental care compared to individuals that had two or more periodontal or prophylactic treatments annually for 3 years.[5]

There is clear evidence that health insurers are ramping up their oral health programs that many established in 2005–7. Several major insurers have announced expanded oral health-related programs for their insureds that are pregnant and those with kidney disease, cerebrovascular (stroke) conditions, head and neck cancer and organ transplants.[6] Leading health insurers seem to have concluded that supporting and even incenting better oral health access and care is good business. It should be so for our publicly supported programs as well. The taxpayers of this country should demand it.

I urge the subcommittee to consider following the lead of these insurers by capitalizing on our Nation's investment in the National Institutes of Health, and institute policy changes that would enable Medicare and Medicaid enrollees with such chronic conditions to access appropriate high quality oral health treatments.

Another key point for the subcommittee to consider is that it is not enough to simply establish coverage or even more dental clinics, as many low-income Americans do not seek dental care until they have oral pain. While addressing pain and suffering is meritorious in its own right, avoiding that pain and suffering and more

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[2] *http://www.bcbsm.com/pr/pr_08–27–2009_71090.shtml.*

[3] Jeffcoat M, et al. CIGNA, Does Treatment of Oral Disease Reduce the Costs of Medical Care? Medscape Today. October 19, 2011. On-line: *http://www.medscape.com/viewarticle/751609.*

[4] *https://secure.ucci.com/ducdws/dental.xhtml?content=dhc-conditions&s1=ucwellness-oral-health-study&s2=results-ucwellness-oral-health-study.*

[5] Mosen D, Pihlstrom D, Snyder J, Shuster E. Assessing the association between receipt of dental care, diabetes control measures and health care utilization. *JADA* January 2012 143(1): 20–30.

[6] *http://newsroom.cigna.com/article_display.cfm?article_id=1287.*

expensive treatment interventions is our goal. The undervaluing of oral health in America is, from our perspective, one of the greatest health literacy challenges we have. Our health center is involved in a generational effort to address health literacy issues that shape the current practice among many high-risk, low-income populations. A major initiative is needed to help convince our residents of the importance of oral health to general health and of the importance of regular dental checkups in maintaining good oral health. Developing more reliable and internally consistent estimates of population access to oral health services should be considered part of that effort. I make this point because it appears that the proportion of children, adolescents and adults who use the oral health care system in the past year is actually well below what many people believe. The percent of residents aged 2 and older who received a dental service in 2007 is estimated by Healthy People 2020 to be 44.5 percent. Our national goal for 2020 is 49 percent. However, widely cited estimates based on health interview survey data using self-reported information is in the range of 20 percentage points higher. Although such widely diverse estimates cannot be reconciled without further work, I note that the higher estimate is based on self-report data that requires recall on long past events making such estimates generally less reliable than those based on observed expenditures. I urge the subcommittee to explore this information further as it has significant implications for dental workforce projections, as well as understating the need to integrate medicine and dentistry to help address the oral health literacy issue.

We must strive for a future where people better understand the importance of daily oral hygiene, proper nutrition, and regular dental checkups not just to their oral health but to their overall health as well. We believe success in this effort is tied to convincing our medical colleagues to help educate their patients on the importance of good oral health care and regular dental checkups. This is made more difficult by the fact that our Nation's medical schools by and large pay little attention to the oral cavity in medical student training. This is evidenced by the response to 2012 survey question by the AAMC of our Nation's graduating medical students on, "How well do you feel that your medical school has trained you to address oral/dental health topics?" Apparently, students were underwhelmed as 32.4 percent of the Nation's graduates checked "not well trained at all" and only 1.3 percent checked "very well trained." Our vision for the future is that our physician community treat the importance of regular oral health checkups on a par with their counseling of patients on the need to be immunized, receive clinical preventive services, exercise, and eat right. In addition to the virtual teaming I mentioned earlier, our dental teams should be aided by an integrated electronic medical record, to engage patients on the importance of receiving clinical preventive services in medicine. Currently we do blood pressure checks and non-fasting blood sugars under protocols in our dental centers. These efforts can have a direct impact on morbidity and even mortality in our patients as evidenced by a recent message one of our hygienists received from a dental patient:

> "You know I thought that it seemed dumb that you would take blood pressure at the dentist office until I had a friend of mine come here and you guys took his blood pressure in hygiene and wouldn't even see him. You sent him right over to the emergency room. Good thing you did, they took him into emergency surgery. I guess they said he was ready to pop."

We should expect this type of coordination in our health care system. Additional examples of teaming across medicine and dentistry are provided in Attachment 2.

I'd like to conclude my testimony by sharing some observations regarding dental workforce and dental education issues. Early on, we recognized that to be successful in our dental initiative we could not ignore workforce and dental education issues that might confound our progress. Figure 5 indicates that given current rates of dental school production, the age distribution of dentists in Wisconsin portends a shortage of dentists. Over the next 20 years, 2.2 dentists are likely to retire for each new dentist entering practice. As if this is not bad enough, two factors may further aggravate the situation for northern rural communities. First, there currently exists a marked preference of dentists to locate in suburban or urban areas of our State relative to the less populated communities. Second, retiring dentists are predominantly male, while new graduates are gender balanced and female dentists in Wisconsin have shown an even more marked preference for suburban or urban practices. Rural Wisconsin loses on both of these. We are hoping to meet this challenge by establishing, in partnership with Marshfield Clinic, a dental residency program and by providing dedicated space within our dental facilities for dental students.

As we continue to grow our dental system to enlist nearly 50 dentists in this work by years end, we can reflect on the opportunity we have had to hire dentists trained in over a dozen dental schools across the country. Most dental schools are urban-

based and specialty-oriented. Most provide students with less exposure than we would like to treating developmentally disabled patients and young children. Nationally, as I speak with my health center colleagues, not enough graduates are interested in careers in the safety-net. Ed O'Neil, director, UCSF, Center for the Health Professions, Center on Recommendations for Reform (3/7/07) said it best:

> "For instance, in many specific locations the Nation is experiencing a raging epidemic of pediatric dental disease. In face of this reality, does it make sense to prepare more young men and women with the skills to serve the bungalow-based smile clinics that serve the suburbs? Instead, shouldn't we align the training with the needs of community clinics to organize and deliver a broad range of preventative and therapeutic services to the population that is experiencing the epidemic?"

As a nation we should not lose sight of the importance of oral health to general health, and the importance of oral health in its own right. What some of us take for granted is currently beyond the reach of many. Discussions I have had with many well-educated people on the problems lower income people face obtaining dental care usually result in surprise. They didn't know. There is a reason the Surgeon General referred to this problem as a "silent epidemic."

I thank the subcommittee for this opportunity for me to share what we've learned and most importantly for taking up this subject, it may still be an epidemic but let it be silent no longer.

Figure 1

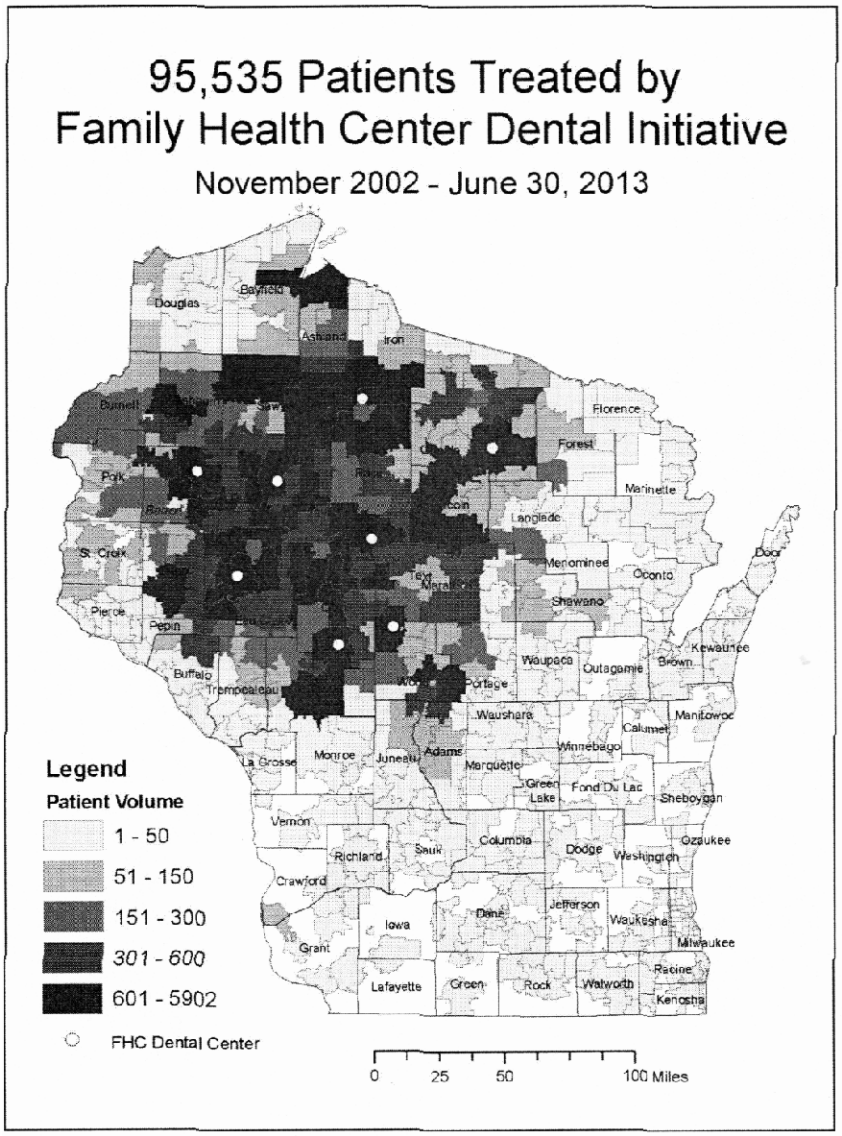
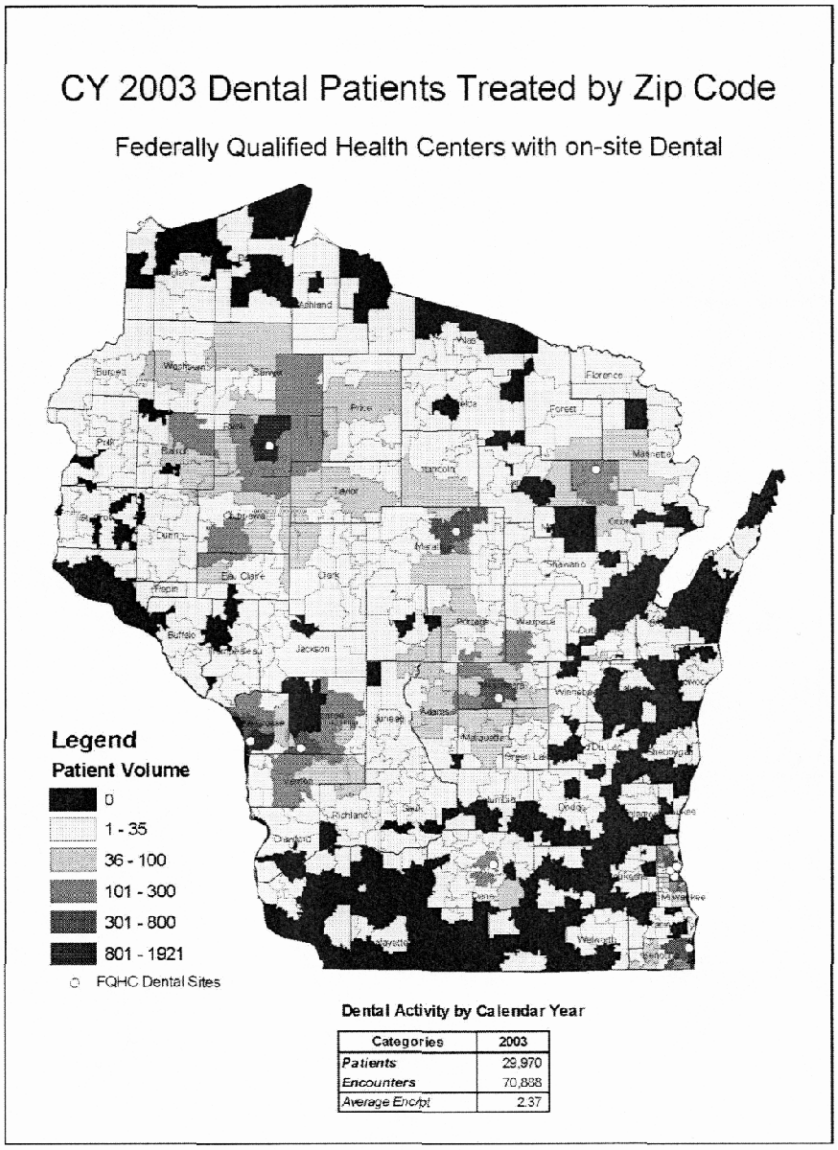
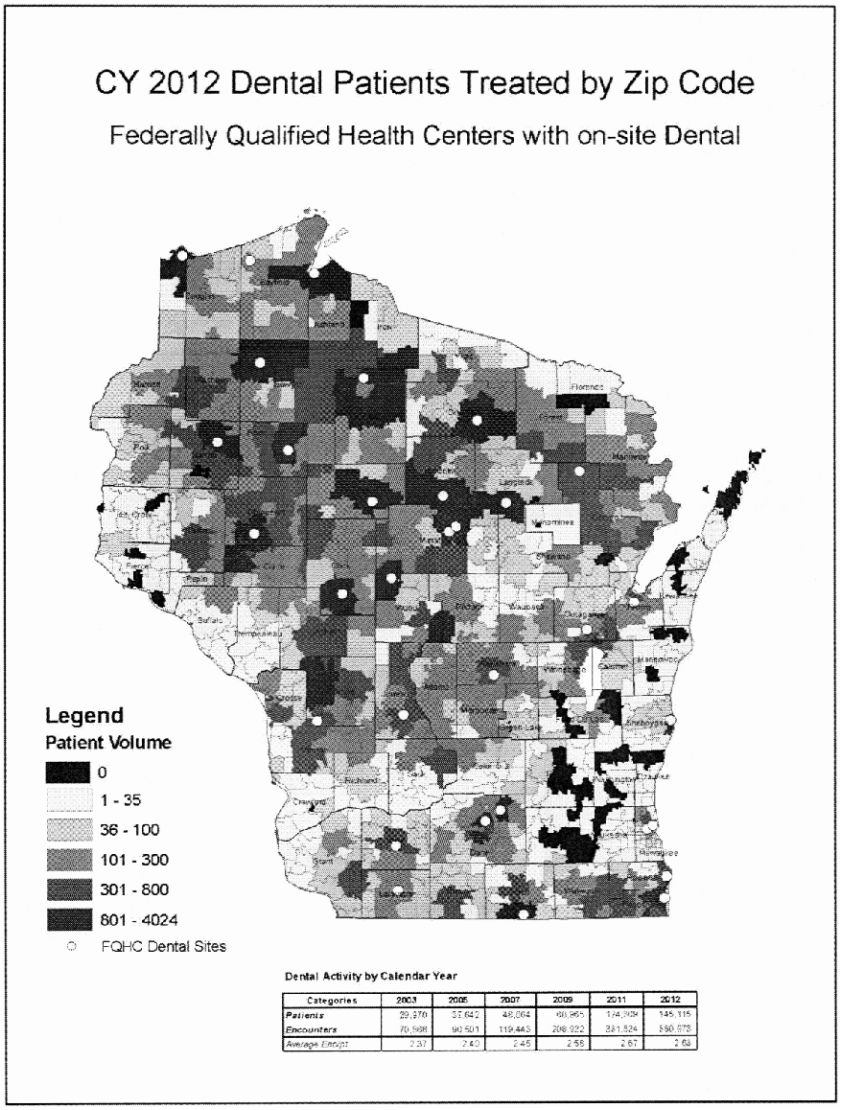

95,535 Patients Treated by
Family Health Center Dental Initiative
November 2002 - June 30, 2013
Douglas
Bayfield
Ashland
Iron
Florence
Forest
Marinette
Langlade
Menominee
Oconto
Door
Shawano
Kewaunee
Brown
Outagamie
Waupaca
Portage
Waushara
Manitowoc
Calumet
Winnebago
Fond Du Lac
Sheboygan
Ozaukee
Washington
Waukesha
Milwaukee
Racine
Kenosha
Walworth
Rock
Green
Lafayette
Grant
Iowa
Dane
Jefferson
Columbia
Dodge
Sauk
Richland
Crawford
Vernon
La Crosse
Monroe
Juneau
Adams
Marquette
Green Lake
Buffalo
Trempealeau
Pepin
Pierce
St. Croix
Polk
Burnett
Legend
Patient Volume
1 - 50
51 - 150
151 - 300
301 - 600
601 - 5902
FHC Dental Center
0
25
50
100 Miles

Figure 2



Categories	2003
Patients	29,970
Encounters	70,868
Average Enc/pt	2.37

Figure 3



Categories	2003	2005	2007	2009	2011	2012
Patients	29,370	37,642	48,064	60,965	114,904	145,115
Encounters	70,168	90,501	119,443	208,922	381,524	390,073
Average Encript	2.37	2.40	2.45	2.58	2.67	2.68

Figure 4

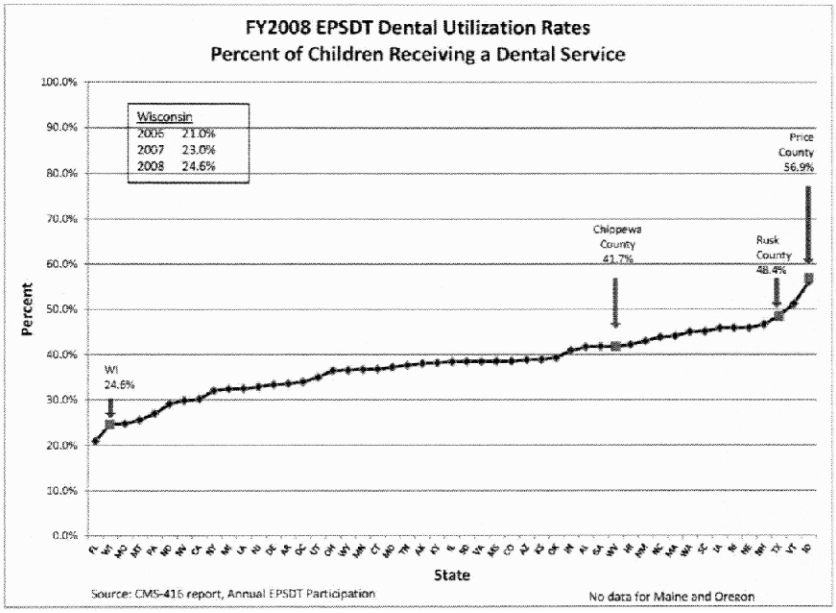
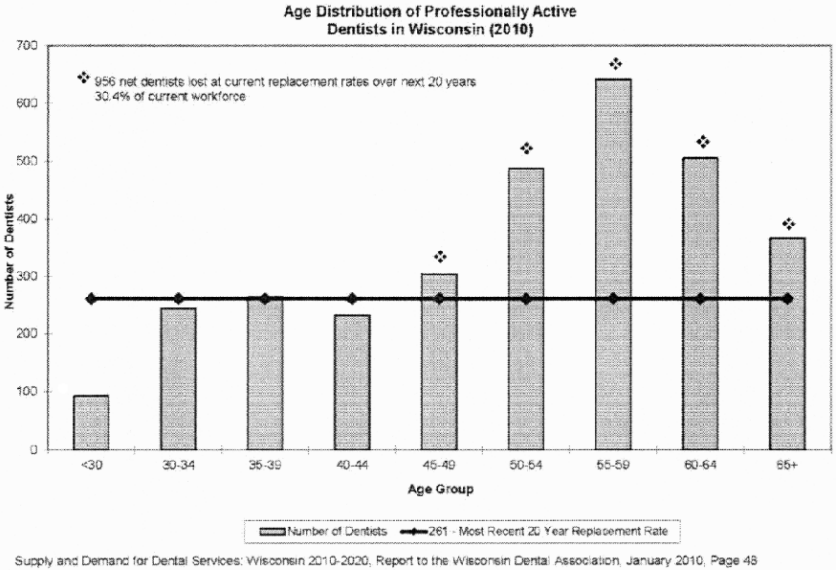


Figure 5



ATTACHMENT 1.—A BRIEF SUMMARY OF THE EVIDENCE BASE FOR INTERVENTION TO IMPROVE ORAL HEALTH AMONG INDIVIDUALS WITH DIABETES

DIABETES AS A PANDEMIC THREAT TO ORAL HEALTH

Physiology does not respect the disciplinary divide that separates the medical from the dental care of the diabetic patient. Diabetes (DM) is a pandemic in the United States: in many counties, over 10 percent of people over 20 years old are affected.[1] The disease is accompanied by wide-ranging health consequences that worsen if it is poorly controlled. To use the legal vernacular, it is established beyond a reasonable doubt that DM has a deleterious effect on periodontal disease (PD) and the evidence is mounting on the impact of periodontal health on diabetic control.[2] The evidence supporting a link between PD and DM is so strong that PD has been classified as the 6th complication of diabetes.[3] DM now affects nearly 26 million Americans and over the next decade, an estimated 40 million more adults could develop the condition, and its complications are expensive. Absent changes, the surge in new cases could add an estimated $512 billion to annual health care spending by 2021 . . . ".[4] In spite of this knowledge, only 55.6 percent of the U.S. population aged 2 years and older with diagnosed diabetes had been to the dentist in the past year.[5] Moreover, severe disparities exist in dental access based on income, insurance status, educational attainment and race.

COMPREHENSIVE DESCRIPTION OF THE MODEL AND SUPPORTING EVIDENCE BASE

The Institute of Medicine (IOM), National Academy of Sciences, released a report, "Dental Education at the Crossroads: Challenges and Change," in January 1995, calling for greater collaboration between medicine and dentistry. The report said closer integration was needed between dentistry and medicine on all levels of the health care system: research, education and patient care. In 2000 Surgeon General David Satcher's report entitled "Oral Health in America" was released. The report focused attention on a national problem which had gone largely unrecognized for decades: the oral health crisis. Dr. Satcher emphasized that oral health does not only encompass teeth. He underlined the importance of recognizing the integration between oral and systemic health and the profound mutual impact that one has on the other, stating that one cannot have systemic health in the absence of oral health. To emphasize this point, he summarized the existing evidence that points to important links between oral disease, such as PD, and systemic diseases such as DM, heart disease and stroke, respiratory health and fetal health (miscarriage and stillbirth). The Surgeon General further exposed disproportionate access to dental health care encountered by disparity-prone populations including low-income individuals, those with no insurance, children, the elderly, handicapped and institutionalized patients who experience what he dubbed the "silent epidemic" when referencing the high rate of oral disease prevalent among these populations.

The report revealed how a struggling and stagnated dental industry that was experiencing workforce shortages exacerbated the problem by denying access to vulnerable populations without the ability to pay for, or access services. His report revealed how, in addition to the systemic ramifications of poor oral health, far reaching consequences were inflicted on those with limited or no access, including high social and economic cost to the individual, negative impact on quality of life and the burden this also placed on society. Importantly, the Surgeon General emphasized that this trend was reversible and preventable and pointed to the importance of bringing education and research to bear on the problem as actionable ways to advance oral-systemic health. Dr. Satcher called for further investigations into oral-systemic health connections, health disparity research, community-based, public health and behavioral health initiatives, health services research, and an expansion in diagnostic and treatment options which would emphasize proactive disease prevention. His report emphasized that for three decades improvement in oral health had been a focus area of U.S. Department of Health and Human Service's Healthy People initiative and that solving the problem would require a concerted effort between the health care industry including professionals and health care entities, academia, the government, health insurers and patients. Notably, 13 years later, oral health remains a priority focus in Healthy People 2020, with many objectives remaining to be achieved.[6]

A chasm currently exists between our perceptions, financing, and delivery of oral health services and general medical services. It persists despite mounting evidence that it should not. Yet today, proportionately fewer of us annually access oral health services than medical services. Our oral health record for some of our most vulnerable citizens is abysmal. The elderly, where chronic disease is more prevalent, have the lowest rate of dental insurance of any age group.[7] Poor children on Medicaid/

CHIP have public dental insurance, but low reimbursement rates and other problems have left most without annual oral health services. Poor adults have even less coverage and access.

This trail leads to an important question, "If the future is medical homes and ACOs, where is oral health in that calculus? Why isn't it more prominent when evidence exists to support its inclusion in these new models/systems."

BRIEF SUMMARY OF THE EVIDENCE BASE

PD is a broad term encompassing a complex disease initiated by a variety of pathogens, largely anaerobic bacteria which establishes a niche in dental plaque that they lay down to protect themselves from exposure to oxygen. The disease is not a single entity and may, or may not exhibit a familial pattern of inheritance. PD may range from its mildest manifestation, gingivitis, a self-limited condition, to severe periodontal disease that is associated with pain, gum erosion, loosening of teeth (attachment loss) and bone loss below the affected tooth and eventually, if untreated, loss of the tooth. PD may be acute and resolve with appropriate treatment (scaling and root planing, sometimes supplemented by antibiotic therapy, and proper oral hygiene) or in a subset of patients, establish chronicity and refractoriness to treatment. PD is a highly prevalent condition among adults in the United States with an estimated 40 percent prevalence rate of moderate to severe disease.[8] Research examining exacerbation of systemic disease in the presence of oral disease and vice versa has produced substantive evidence that such connections are real.[9 10] Much research in the past two decades has explored the validity of the "focal infection theory" that promotes the possibility that organisms present at a focal infection site or their products may gain systemic access and become associated with promulgating other disease processes. PD represents such a focal infection and risks for systemic manifestations increase with establishment of chronicity. Of importance here is that with proper hygiene and regular dental care and education, this disease is largely preventable and its prevention and control could exert considerable far reaching impact on promoting systemic health at multiple levels.

An extensive evidence base exists to support the reintegration of the mouth into the body for everyone.[11] The impact of DM on PD was recognized nearly 50 years ago[12]; Moreover, mounting evidence substantively supports mutual bidirectional exacerbation of these two conditions.[13 14 15] In a systematic review of 48 studies undertaken since the 1960s, 44 studies reported increased prevalence, extent, severity or progression of PD in patients with DM.[16] Interestingly, the observation by two independent studies in 1989[17 18] reported that infectious processes can establish insulin resistance in non-diabetics that can persist for 3 months following resolution of the infectious process, promoted the concept that PD also contributes to diabetic status. Notably, PD is also a risk factor for stimulating diabetes-associated complications.[19 20 21] Adjusted for other risk factors, mortality risks related to ischemic heart disease and diabetic nephropathy were 2.3 and 8.5 times higher, respectively, for individuals with DM and severe PD compared to those with no PD; overall mortality risk from cardio-renal pathology was 3.5 times higher for those with DM and PD compared to subjects with no PD.[20]

The mechanism underlying this bacterial impact on glycemic control is attributed to dysregulation of insulin-mediated glucose uptake at the skeletal muscle level, inducing a state of systemic insulin resistance.[22] Studies among Pima Indians with a high rate of DM[23] and in a population of Japanese patients with DM[24] strongly suggest that DM is a risk factor for PD, likely due to increased susceptibility of diabetic patients to infectious processes due to compromised immunocompetence related to irreversible formation of advanced glycation end products. Proteins mediating immunological functions become compromised due to non-enzymatically mediated glycation and multiple pathological mechanisms converge to induce what manifests as a heightened chronic proinflammatory state that simultaneously exacerbates both the DM and PD pathophysiological processes.[22 25 26] Chronic systemic micro-inflammatory processes have been implicated as a common factor underlying both DM and PD, driving chronicity, progression and mutual exacerbation of these conditions in the absence of intervention. Importantly, micro-inflammatory processes which contribute to disease chronicity appear to be *modifiable* risk factors responsive to PD treatment and regular dental care as well as more advanced therapeutic regimes.[27]

Poor glycemic control is an important factor in PD progression and severity.[28 29] Notably, outcomes of four recent systematic reviews and meta-analyses support the position that glycemic control improves periodontal health, and, conversely, improvement in periodontal health impacts positively on glycemic control.[30 31 32 33 34] Collectively, these results strongly support potential for simultaneous stemming of

epidemic prevalence of both PD and DM through cross disciplinary efforts that systematically target glycemic control and good oral care. Promoting interdisciplinary care processes is pivotal: studies evaluating dentists' understanding of DM–PD bidirectional relationship showed that ≤60 percent promoted this with patients; physician awareness of PD/DM complications was low.[34] Strikingly, interactions between dentists and physicians on oral-systemic patient management were measured at <15 percent in a 2006 U.S. study.[35]

REFERENCES

1. Centers for Disease Control and Prevention. National Diabetes Surveillance System. 2009 [cited 2013 April 02]; Available from: *http://apps.nccd.cdc.gov/DDTSTRS/default.aspx*.

2. Taylor, G.W. and W.S. Borgnakke, Periodontal disease: associations with diabetes, glycemic control and complications. Oral Dis, 2008. 14(3): p. 191–203.

3. Loe H. 1993. Periodontal disease. The sixth complication of diabetes mellitus. Diab Care 16:329–34.

4. Vojta D, De Sa J, Prospect T, Stevens S, Effective Interventions for Stemming the Growing Crisis of Diabetes and Prediabetes: A National Payer's Perspective. Health Affairs, 31, No 1 (2012): 20–6.

5. Healthy People 2020, Summary of Objectives, Diabetes, D–8, Annual dental examinations.

6. Koh, H. 2010. A 2020 vision for Healthy People. NEJM 362: 1653–56.

7. MEPS Chartbook No. 17, Dental Use, Expenses, Dental Coverage, and Changes, 1996 and 2004, AHRQ, DHHS.

8. Fuster V, Badimon L, Badimon JJ, 1992. The pathogenesis of coronary artery disease and the acute coronary syndromes NEJM 326: 242–50.

9. Kim J and Amar S. 2006 Periodontal disease and systemic conditions: a bidirectional relationship. Odontol 94: 10–21.

10. Pizzo G, Guiglia R, Lo Russo L, Campisi G. 2010. Dentistry and internal medicine: from the focal infection theory to the periodontal medicine concept. Eur J Internal Med 21: 496–502.

11. Powell V, Din F, Acharya A, et al., Project on Clinical Data Integration Page 20, Contact points between medical and dental care/research—Version J: Categories (1–29) and references.

12. Belting SM, Hiniker JJ, Dummett CO. Influence of diabetes mellitus on severity of periodontal disease. J Periodontol 1964 35:476–80.

13. Mealey BL, Rose LF. Diabetes mellitus and inflammatory periodontal diseases. Curr Opin Endocrinol Diabetes Obes. 2008;15:135–41.

14. Taylor GW, Borgnakke WS. Periodontal disease: associations with diabetes, glycemic control and complications. Oral Dis. 2008;14:191–203.

15. Nagasawa T, Noda M, Katagiri S, Takaichi M, Takahashi Y, Wara-Aswapati N, Kobayashi H, Ohara S, Kawaguchi Y, Tagami T, Furuichi Y, Izumi Y. Relationship between periodontitis and diabetes—importance of a clinical study to prove the vicious cycle. Intern Med. 2010;49:881–85.

16. Taylor GW, Burt BA, Becker MP, Genco RJ, Schlossman M, Knowler WC. 2001 Severe periodontitis and risk for poor glycemic control in patients with non-insulin dependent diabetes mellitus. J Periodontol 67: 1085–93.

17. Sammalkorpi K. 1989. Glucose intolerance in acute infections. J Int Med 225: 15–19.

18. Yki-Jarvinen H, Sammalkorpi K, Koivisto VA, Nikkila EA. 1989 Severity, duration and mechanisms of insulin resistance during acute infections. J Clin Endocrinol Metab 69: 317–23.

19. Jepsen S, Kebschull M, Deschner J. Relationship between periodontitis and systemic diseases. Bundesgesundheitsblatt Gesundheitsforschung Gesundheits schutz. 2011;54:1089–96.

20. Saremi A, Nelson RG, Tulloch-Reid M, et al. Periodontal disease and mortality in type 2 diabetes. Diabetes Care 2005;28:27–32.

21. Shultis WA, Weil EJ, Looker HC, Curtis JM, Shlossman M, Genco RJ, Knowler WC, Nelson RG. Effect of periodontitis on overt nerphropathy and end-stage renal disease in type 2 diabetes. Diabetes Care. 2007 30: 306–11.

22. Grossi SG, Genco RJ. 1998. Periodontal disease and diabetes mellitus: a two-way relationship. 3: 51–61.

23. Nelson RG, Shlossman M, Budding LM, Pettitt DJ, Saad MF, Genco RJ, Knowler WC. 1990 Periodontal disease and NIDDM in Pima Indians Diabetes Care. 13: 836–40.

24. Nishimura F, Kono T, Fujimoto C, Iwamoto Y, Murayama Y. 2000. Negative effects of chronic inflammatory periodontal disease on diabetes mellitus. J Int Acad Periodontol. 2: 49–55.
25. Genco, R.J., Glurich, I., Haraszthy, V., Zambon, J., DeNardin, E. 1998. Overview of Risk Factors for Periodontal Disease and Implications for Diabetes and Cardiovascular Disease. Compendium of Continuing Education in Dentistry (Symposium Proceedings) 19: 40–4.
26. Collin, HL, Uusitupa M, Nisanen L, Kontturi-Narhi V, Markkanen H, Koivisto AM. 1998, Periodontal findings in elderly patients with non-insulin dependent diabetes mellitus. J Periodontol 69: 962–66.
27. Lalla E and Papapanou PN. Diabetes mellitus and periodontitis: a tale of two interrelated diseases. Nat Rev Endocrinol 2011 Jun 28 Epub ahead of print.
28. Weidlich P, Cimões R, Pannuti CM, Oppermann RV. Association between periodontal diseases and systemic diseases. Braz Oral Res. 2008;22 Suppl 1:32–43.
29. Chávarry NG, Vettore MV, Sansone C, Sheiham A. The relationship between diabetes mellitus and destructive periodontal disease: a meta-analysis. Oral Health Prev Dent. 2009;7:107–27.
30. Darré L, Vergnes JN, Gourdy P, Sixou M. Efficacy of periodontal treatment on glycaemic control in diabetic patients: A meta-analysis of interventional studies. Diabetes Metab. 2008;34:497–506.
31. Janket SJ, Wightman A, Baird AE, Van Dyke TE, Jones JA. Does periodontal treatment improve glycemic control in diabetic patients? A meta-analysis of intervention studies. J Dent Res. 2005;84:1154–59.
32. Simpson TC, Needleman I, Wild SH, Moles DR, Mills EJ. Treatment of periodontal disease for glycaemic control in people with diabetes. Cochrane Database Syst Rev. 2010:CD004714.
33. Teeuw WJ, Gerdes VE, Loos BG. Effect of periodontal treatment on glycemic control of diabetic patients: a systematic review and meta-analysis. Diabetes Care. 2010;33:421–27.
34. Al-Khabbaz AK, Al-Shammari KF, Al-Saleh NA. Knowledge About the Association Between Periodontal Diseases and Diabetes Mellitus: Contrasting Dentists and Physicians. J Periodontol. 2011;82:360–66.
35. Kunzel C Lalla E Lamster IB. Management of the patient who smokes and the diabetic patient in the dental office. J Periodontol 2006 77: 331–40.

ATTACHMENT 2.—EXAMPLES OF THE VALUE TO PATIENTS OF BETTER COORDINATION BETWEEN MEDICINE AND DENTISTRY

Case example: A Family Health Center patient living in Clark County was referred to the Ladysmith Dental Center by his Marshfield Clinic Oncologist. His cancer treatments were negatively impacting on his oral health status, and as a result he began losing weight. The patient was initially scheduled for an emergency visit and followup dental care. All of his teeth needed to be extracted and he was fitted for dentures. To date, the patient has improved oral health and has gained 10 pounds.

Case example: An elderly woman on Medicare presented at our Ladysmith Dental Center with severe diabetes, which was not controlled well due to the condition of her teeth. She had driven over 4 hours one-way to get to our clinic. She had only a few teeth, which had to be extracted. Over several visits we were able to provide her with dentures and in a subsequent visit she reported that she is now eating better and has her diabetes under better control.

Case example: Another diabetic patient presented at our Ladysmith Dental Center. The patient was jaundiced and very ill and had a large lesion on his leg for the past 4 years that would not heal. He also had severe oral health disease. Following a full mouth extraction and dentures, this patient has been back for routine care. He reports his blood glucoses are under control, he has good skin color, his skin lesion is healed and he is very happy.

Case example: A 20-year-old female with no income presented as unemployed and depressed with very poor oral health. We provided extractions and dentures. She now has an improved self image and a job.

Case example: A patient presented at our Ladysmith Dental Center as an emergency. She was in high school at the time of her first visit and she qualified for a full discount under our sliding-fee program. Due to the extensive dental care needed and her family's inability to afford that care, she was not able to find a dentist that would see her. Her extensive dental care included root canals, crowns, and major fillings in the majority of her top teeth. To date, the cost of her care exceeds $5,000. She is now an established patient with the dental center and the majority of the work was completed in time for her senior picture.

Case example: A teenage child with spina bifida presented to clinic to establish care with a new pediatrician. The examination revealed multiple severe dental caries requiring extraction and repair. This child had just been hospitalized for many months to repair and heal her third sacral decubitus. Pediatrician requested prompt dental treatment to decrease the potential for additional infections that could jeopardize skin integrity. Pediatric care coordinator and special needs dental coordinator worked together to arrange dental treatment under anesthesia with appropriate skin pressure relief measures in place to prevent possible skin breakdown. Dental health was achieved, skin integrity was maintained and potential for additional infections due to decay and gum disease reduced. This child also had improved self-esteem and improved social interactions with peers.

Case example: A teenage patient with special needs presented to the pediatrician for a well-check. Patient has profound cognitive impairment, no speech, aggressive behavior and is completely uncooperative with examinations. Patient had previously received dental care and treatment under anesthesia and was in need of a dental exam with cleaning again. Pediatrician requested additional specialty care examinations and procedures be done in conjunction with the scheduled dental service. Pediatric care coordinator and special needs dental coordinator were able to arrange eye exam, gynecological exam, ENT exam, blood draw for lab testing and vaccinations to take place while patient was anesthetized for the dental procedure.

Senator SANDERS. Thank you very much, Mr. Nycz.

Ms. Stallings.

STATEMENT OF CATHI STALLINGS, MSW, FALLS CHURCH, VA

Ms. STALLINGS. Good morning, Chairman Sanders and distinguished members of the subcommittee. My name is Cathi Stallings, and I am a social worker from Falls Church, VA. I am here as someone who knows firsthand that dental care is a luxury that many millions of us in America cannot afford. I have paid thousands of dollars for dental work and need much more.

I, personally, am focused on this issue because I am not able to afford to pay the exorbitant cost for the dental work that I need. Since finding out the extent of my dental needs, I have spent many dark hours wondering how I will afford my future.

Several years ago, I took out a bank loan to pay for a bridge that I needed. I was told a few months ago that the bridge needs to be replaced. I was quoted the price of $7,000 for this. The periodontist said he would give me a discount, but it didn't matter. I couldn't afford that, either.

I have quite a few other dental issues. The insurance coverage with my job covers $1,290 per year, which doesn't cover even one of the crowns I need, let alone anything else. Crowns have been quoted to me up $2,000 each. In the past 2 months, I've needed scaling and root planing for gum disease, as well as an emergency crown when one of my teeth cracked.

As a social worker, I work with severely mentally ill clients, most of whom have not been able to afford to go to a dentist in many years. One issue for them is that numerous medications cause dry mouth, but with psychotropic medications, there can be a more severe effect, as it usually takes more than one medication to treat the mental health symptoms. Saliva helps in preventing dental pathologies, like cavities and gum disease, by the cleansing and antibacterial action.

One of my clients has very few teeth left. He found out 2 weeks ago that he has three abscesses in his remaining teeth. His Medicaid benefits only provide extractions of teeth, but no dental services. If more of his teeth are pulled, he said he doesn't know how he'll be able to eat.

Another one of my clients receives general relief funds of $220 per month to live on. I gave her information about a dentist who was providing a free emergency exam and x-rays. She went and found out that she needs scaling and root planing for her gum disease. The total price that was quoted to her for this procedure was $1,600. I then directed her to a lower cost dental service this summer, and she was told that they may have an opening in November, since there is such a long waiting list.

This week, I was told by another client that he was told in 1999 that he had 11 cavities. He has never been treated for any dental work in all these years. He said, "I guess I'm on my way to a root canal, because I do feel a sensation in my mouth."

I had an extremely unusual birthday this year. As I was preparing to go out and celebrate with my mother, I heard on the news about the Maryland Mission of Mercy clinic, where free dental services were being provided. Immediately, I ran out of my home, met my mom outside and told her, "We have to cancel my birthday. I have to go to Laurel, MD."

We went and were told they were full for the day, but that I could try again tomorrow. I knew that dental care was much more crucial than celebrating my birthday. So that evening, I went back to Laurel and arrived around 8 p.m. I was No. 2 in line. I was thinking that I wish I could have brought all my clients with me.

Many others started to show up as time went on. We shared our stories of dental nightmares. I spent the night on the sidewalk, but I didn't mind, because I was getting a great birthday gift. It turns out that the gift was seeing over 400 volunteers in action, giving their time and hearts to provide over $750,000 worth of free dental work that weekend.

I wasn't able to get the dental services I was hoping for, as they weren't able to do specifically what I needed. But I came away with a scene that I will never forget—men and women of every race, creed, and color lined up for what seemed like a mile, in dire need, with the hope of being helped. It was truly heart-breaking for me to see.

I have learned that the lack of adequate dental care can lead to diabetes, chronic heart disease, and strokes. These risks are scary for me and so many others. But you have the solution in your hands.

I am a social worker. These are my clients. But on this issue, all of us are standing together in the same line, looking for help. I beg you to pass this legislation so that help can be provided to all.

Thank you for your valuable time and attention to this critical matter.

[The prepared statement of Ms. Stallings follows:]

PREPARED STATEMENT OF CATHI STALLINGS, MSW

Good morning Chairman Sanders and prestigious members of the subcommittee. I appreciate the opportunity to speak before you today. My name is Cathi Stallings, and I am a social worker from Falls Church, VA.

I am here as someone who knows firsthand that dental care is a luxury that many millions of us in America cannot afford. I have paid thousands of dollars for dental work and need thousands more.

I personally am focused on this issue because I am not able to afford to pay the exorbitant cost for the dental work that I need.

Since finding out the extent of my dental needs, I have spent many dark hours wondering how I will afford my future. Several years ago I took out a bank loan to pay for a bridge that I needed. I was told a few months ago that that bridge needs to be replaced. I was quoted the price of $7,000 for this, but the periodontist said he would give me a discount.

I have quite a few other dental issues. The insurance provided with my job covers only $1,290 per year, which does not cover even one of the crowns I need, let alone anything else (they have cost me about $2,000 each). In the past 2 months, I've needed scaling and root planing for gum disease, as well as an emergency crown when one of my teeth cracked.

As a social worker, I work with severely mentally ill clients, MANY of whom have not been able to afford to go to a dentist in years. Numerous medications cause dry mouth, but with psychotropic medications there can be a more severe effect, as it usually takes more than one medication to treat the mental health symptoms. Saliva helps in preventing dental pathologies, like cavities and gum disease, by the cleansing and antibacterial action.

One of my clients has very few teeth left. He found out 2 weeks ago that he has three abscesses in his remaining teeth. His Medicaid benefits provide only extractions of teeth—no dental services. If more of his teeth are pulled, it will become increasingly difficult for him to eat.

Another one of my clients receives General Relief funds of $220 per month to live on. I gave her information about a dentist who was providing a free emergency exam and x-rays. She went and found out that she needs scaling and root planing for her gum disease. The total price quoted to her for this procedure was $1,600. I then directed her to a lower cost dental service this summer, and she was told that they may have an opening in November, since there is such a long waiting list.

Every day my clients pay for the consequences of their illness and their inability to support themselves.

I had an extremely unusual birthday this year. As I was preparing to go out and celebrate with my mother, I heard on the news about the Maryland Mission of Mercy clinic, where free dental services were being provided. Immediately, I ran out of my home, met my mom outside and told her, "We have to cancel my birthday. I have to go to Laurel, MD."

We went and were told they were full for the day, but that I could try again tomorrow. I knew that dental care was much more crucial than celebrating my birthday. So that evening, I went back to Laurel and arrived around 8 p.m. I was No. 2 in line.

Many others started to show up as time went on. We shared our stories of dental nightmares. I spent the night on the sidewalk, but I didn't mind, because I was getting a great birthday gift. It turns out that the gift was seeing over 400 volunteers in action giving their time and hearts to help give over $750,000 worth of free dental work that weekend.

I wasn't able to get the dental services I was hoping for, as they weren't able to do specifically what I needed. But I came away with a scene that I will never forget—men and women of every race, creed and color lined up for what seemed like a mile—in dire need, with the hope of being helped. It was truly heart-breaking for me to see.

I have learned that the lack of adequate dental care can lead to diabetes, chronic heart disease and strokes. These risks are scary . . . for me and so many others. But *YOU* have the solution in your hands.

I am a social worker. These are my clients. But on this issue ALL of us are standing together in the same line, looking for help.

I beg you to pass this legislation so that help can be provided. Thank you for your valuable time and attention to this critical matter.

Senator SANDERS. Ms. Stallings, thank you very much.

Dr. Hughes.

STATEMENT OF DEBONY R. HUGHES, D.D.S., PROGRAM CHIEF, DENTAL HEALTH PROGRAM AND DEAMONTE DRIVER DENTAL PROJECT, PRINCE GEORGE'S COUNTY HEALTH DEPARTMENT, CHEVERLY, MD

Ms. HUGHES. Good morning. I am a public health dentist. As Senator Sanders stated, I began my career in public health 21 years ago in Vermont, and for the past 7 years, I have been the program chief of the dental health program for Prince George's

County Health Department. Last fiscal year, we provided more than 3,200 clinic visits to children and pregnant women.

In addition, we provide oral health education across the county and work with community organizations. Working with patients, clinicians, health administrators, and community organizations has given me insight on the state of oral health both locally and nationally.

I would like to thank Chairs, Senator Sanders and Senator Burr, and committee members for this opportunity to share information about the climate and landscape of dental access and cost issues in my jurisdiction.

Let me begin by telling you about some experiences that influence my remarks today and inspire my work. In Vermont, I lived in a small town with a population of approximately 8,000, and there were four private dental offices. At that time, Vermonters eligible for Medicaid did not have access to any of those four dental offices.

With the help of a community organization, we were able to provide care and expand access to Medicaid-eligible residents. In Prince George's County, the Health Department provides a similar safety net for dental care.

Recently, I participated in my first Mission of Mercy. This 2-day, large-scale event provided free dental care to uninsured adults. Men and women camped out overnight, waiting to be served. Many received quality care, but patients should not have to endure such conditions to receive treatment.

This experience affirmed my belief that dental care is not a luxury, but rather a necessity, and we must make it accessible to all adults. But achieving this goal will be difficult if we are unable to address rising operational costs of dentistry.

Of course, we cannot talk about the high cost of dentistry without acknowledging the cost of dental education. It's not uncommon for a dentist to graduate with a debt of over $200,000, and, arguably, education costs play a role in access and driving cost.

But operating a practice is the true cost driver. For example, building out a dental office can cost up to $500,000 for equipment alone. Coupled with the escalating costs of staff salaries, insurance premiums, dental supplies, laboratory fees, and equipment upkeep, which are largely unknown to those outside the field of dentistry, a practice can experience staggering costs. My clinic recently had repairs on an x-ray unit, and the labor fee alone was $295.00 per hour.

For many consumers who have neglected their dental care, extensive treatment is often required, and it can be expensive. For example, according to the American Dental Association's 2011 survey of dental fees in the South Atlantic Region, the average cost of a root canal is $1,075. Add in the cost of a crown, and the fee increases an additional $1,079.00. Of course, the less expensive option is to have the tooth pulled, but this choice can lead to problems with chewing, speech, and appearance.

Can dental costs be contained? This is a question I cannot answer. But it is important for consumers to know what drives their cost. As a public health dentist, I think about education, preven-

tion, outreach, and obtaining more resources to provide increased accessibility to care.

In Prince George's County, there is an established mobile health fleet that provides medical and dental care to public schools. The county health department operates the Deamonte Driver Dental Project, which is a mobile dental unit funded by the Maryland Office of Oral Health, providing care to children.

We address the emergent needs and provide resources for families to establish a dental home. We work with volunteer dentists in the neighborhoods of the schools we service to provide a resource for families that will continue the efforts to make dental care easily accessible.

Last fiscal year, the project provided care to more than 2,300 children on a budget of $180,000. Mobile units are not a panacea for treatment, but they are certainly a model for providing affordable dental care.

Prevention is an important aspect of reducing costs for dental treatment. After the death of Deamonte Driver, Governor O'Malley assembled the Dental Action Committee. One of the recommendations was to institute school-based oral health screenings program. The Maryland Dental Action Coalition, formed from the original Dental Action Committee, received $172,000 from the Kaiser Foundation to develop a demonstration project to determine the feasibility of this type of program in Prince George's County.

The results of the project showed that it is vital to have a presence in the schools. Of 3,000 children screened, 200 were in the A category, potential Deamonte Drivers, which indicated that they had an immediate need, either infection or multiple decayed teeth.

It is these types of programs that will address affordable accessibility. We need a stronger financial commitment to support the public health infrastructure so that the dental needs of all Americans can be met.

Thank you again for the opportunity to address this crisis.

[The prepared statement of Ms. Hughes follows:]

PREPARED STATEMENT OF DEBONY R. HUGHES, D.D.S.

Good morning. My name is Dr. Debony Hughes and I am a public health dentist. I began my career in public health 21 years ago in Vermont and for the past 7 years I have been the Program Chief of the Dental Health Program for Prince George's County Health Department in Maryland. Last fiscal year, we provided more than 3,200 clinic visits to children and pregnant women. In addition we provide oral health education across the county and work with community organizations. Working with patients, clinicians, health administrators and community organizations has given me insight on the state of oral health both locally and nationally.

I would like to thank chairs Senator Sanders and Senator Burr and committee members for this opportunity to share information about the climate and landscape of dental access and costs issues in Prince George's County.

Let me begin by telling you about some experiences that influence my remarks today and inspire my work in Prince George's County.

In Vermont, I lived in a small town with a population of approximately 8,000 and there were four private dental offices. At that time, Vermonters eligible for Medicaid did not have access to any of those four dental offices. With the help of a community organization, we were able to provide care and expand access to Medicaid eligible residents. In Prince George's County, the Health Department provides a similar safety net for dental care.

Recently, I participated in my first Mission of Mercy, a large-scale event providing free dental care to uninsured adults. For 2 days dental professionals treated hundreds of adults each day. I was overwhelmed to see so many amassed to receive treatment. People slept overnight in hopes to receive care. Many received quality

care but I believe patients should not have to endure those types of conditions to receive treatment.

These experiences reminded me that quality dental care is not a luxury, it is a necessity and we need to make it accessible and affordable for adults to receive the care they need and deserve.

These experiences also tell me that this task will remain difficult if we are unable to address the escalating costs of dental education and the escalating operational costs of dentistry.

There are several factors that influence the correlation of dental insurance coverage and utilization, access to care, and high costs of dental care which leads to more extensive and expensive treatments.

Providing dental care is costly. When we talk about the high cost of dentistry, we need to look at the several aspects of care. First, let us consider the costs of a dental education. It is not uncommon for dentist to graduate with a debt of over $200,000. Establishing an office can cost up to $500,000 for equipment alone. The escalating costs of staff salaries, insurance premiums, dental supplies, laboratory fees and equipment upkeep are staggering and largely unknown to those outside the field of dentistry. Our clinic recently had a repair done on an X-ray unit. The labor fee alone was $295.00 per hour.

For many people who have neglected their dental care for a variety of reasons, extensive treatment may be required. For example, a root canal, a procedure that requires removing the infected nerves in the root of a tooth can cost on average, of $1,075 according to the American Dental Association's 2011 Survey of Dental Fees in the South Atlantic Region. This fee does not include the cost of the crown, which averages $1,079.00. The less expensive option is to have the tooth pulled which can lead to other problems that can affect chewing, speech and appearance.

With these types of exorbitant costs to maintain a quality practice, the costs for dental procedures have to stay competitive with the supporting costs of the practice. Can these costs be contained? I am not in the position to answer this but it is important for consumers to know what drives the costs in dentistry.

As a public health dentist, I think about education, prevention, outreach and obtaining more resources to provide increased accessibility to care. In Prince George's County, there is an established mobile health fleet that provides medical and dental care to the public schools. The county health department operates the Deamonte Driver Dental Project (DDDP), which is a mobile dental unit. This project honors the legacy of Deamonte Driver by providing dental care to Title I schools, which includes the school he attended. The project, funded by the Maryland Office of Oral Health, allows us to provide care to insured and uninsured children. We address the emergent needs and provide resources for families to establish a dental home. We work with volunteer dentists in the neighborhoods of the schools we service to provide a resource for families that will continue the efforts to make dental care easily accessible. Last fiscal year the DDDP provided care to more than 2,300 children on a budget of $180,000. Mobile units are not a panacea for treatment but they are certainly a model for providing affordable dental care.

Prevention is an important aspect of reducing costs for dental treatment. After the death of Deamonte Driver, Governor O'Malley assembled the Dental Action Committee (DAC). One of the recommendations was to institute school-based oral health screening programs. The Maryland Dental Action Coalition, formed from the original DAC, received $172,000 from the Kaiser Foundation to develop a demonstration project to determine the feasibility of this type of program in Prince George's County. The results of the project showed that it is vital to have a presence in the schools. Of 3,000 children screened, 200 were in the A category which indicated that they had an immediate need, either infection or multiple decayed teeth. This indicated 200 more potential Deamonte Drivers.

It is these types of programs that will address affordable accessibility. We need a stronger financial commitment to support the public health infrastructure so that the dental needs of all Americans can be met.

Thank you again for the opportunity to address this crisis.

Senator SANDERS. Thank you very much, Dr. Hughes, and come back to Bristol. We can use you.

There's a lot to go over. What I propose is that we can do this kind of informally. I would like to ask each of you questions, but at the end of the response, if others want to jump in and comment, that would be great.

Let me tell you a little story about Vermont. About 45 years ago, I moved to a small town in rural Vermont in what we call the Northeast Kingdom. I saw a kid there, a neighbor of mine. I'd never seen anything like it in my life. He was maybe 10 years of age, and all of his teeth were rotting in his mouth. I'd never seen anything like that in my life.

It turned out that he was certainly not unique. We had a major problem in Vermont then. Over the years, in our State, we have made some significant progress, and we've done it primarily through the establishment of Federally Qualified Health Centers around the State. We now have 43 locations, eight FQHCs, and in our small State, about 25,000 people are getting treated, regardless of income, at the community health centers.

We have established—and this is really a source of great satisfaction. In low-income areas, way up in the Northeast Kingdom—Dr. Hughes, you may remember—in the towns of Richford, in Plainfield, in Burlington, we have state-of-the-art dental clinics that I think are fairly cost-effective, because we have a number of dentists and dental technicians who are practicing there. We have a long way to go.

Now, let me at least start off by saying this. What we have learned in Vermont is that every time you build—it's like, "If you build it, they will come." It's like the baseball fields. What we have learned is you build a dental clinic, and guess what? People come.

Dr. Catalanotto, is that your impression, that the need is out there, and if we build it, people will come?

Mr. CATALANOTTO. Absolutely. I look at my own examples in Florida. At our dental school, which is very large, we have patients who travel 2 hours away, because they can't find affordable care in their communities. When I went to Gadsden County next to the State capital of Tallahassee, on the day we did a school exam, one in five children reported pain that day of the exam.

Senator SANDERS. One in five children?

Mr. CATALANOTTO. One in five children on the day of the exam—this was about 5 years ago—reported pain, one in five, Senator. A young graduate of ours went to the county health department and took a job. She's a pediatric dentist who gave up what she could have made in private practice to work in the county health department. Overnight, she made it a major success with large numbers of patients. So, yes, the need is out there. People will come if provided access to the services at an affordable cost.

FQHCs are a wonderful partner in doing this. I will tell you, as an example, all of my dental students at the University of Florida spend approximately 6 weeks of their clinical year in an FQHC. Why do the FQHCs love that? It's not the short-term labor they get. It's that these students finally figured out, "This is a place I might practice." It's no longer the private practice model. They see the opportunity, sir.

Senator SANDERS. Let me ask you a tough question, but it's just between you and me.

Mr. CATALANOTTO. Yes, sir.

Senator SANDERS. I have the impression today that maybe there are some great dentists out there who see their job as treating people in need. But it is also no secret that there are a lot of dentists

who graduate dental school deeply in debt—and I want to talk about that in a moment—who are making a pretty penny by treating the upper middle class. If you look in the Yellow Pages, they've got a beautiful smile, and they do all the cosmetic dentistry. So we have a lot of dentists practicing cosmetic dentistry when kids are in pain.

Mr. CATALANOTTO. Yes.

Senator SANDERS. What do we do? What ideas do you have? And I should tell you we've tried substantially increasing funding for the National Health Service Corps, which you're familiar with. What do we do to create the kind of dental workforce that we need so that we don't have to be embarrassed that there are huge places in America where people—either there are not enough dentists, or there are not enough dentists treating low- and moderate-income people? What's your ideas on that?

Mr. CATALANOTTO. I can give you three answers. We do need to improve Medicaid reimbursement. In Florida, we have the worst Medicaid reimbursement in the United States. The result is that only 10 percent, approximately, of Florida dentists are accepting Medicaid.

Senator SANDERS. Say that again. I want everybody to hear that. You have Medicaid, but only 1 in 10 dentists will take Medicaid patients.

Mr. CATALANOTTO. That is all, but it's because we have some of the lowest Medicaid reimbursements in the United States. No. 2, I think there is very clear data that things like National Health Service Corps scholarships and loan forgiveness programs are wonderful. There are some States that have them.

We do not have them in Florida. I am happy to say that the Florida Dental Association has lobbied our State legislature, but our State legislature is just too cheap to do it.

Third—and this is the longer-term solution—HRSA Title VII funding provides grants to dental schools. The newest set of grants is to help change the culture of the dental school and the culture of dental students. They focus on healthcare disparities.

I am the principal investigator of one of those grants to the University of Florida College of Dentistry. And what we are doing is revamping our curriculum to produce students who are more culturally competent and sensitive to the needs of the underserved patients. They have more public health experience. I've been able to hire a public health dentist to add to my faculty.

So now second-year dental students go out into a school-based setting, where they understand. They go into schools of poverty. They see the picture early in their dental education. Our goal and our hope is that they will become more sensitive to this issue after they graduate.

Senator SANDERS. And are you finding—and we have the same issue—we had a hearing here on primary healthcare, getting doctors, young medical students, involved in primary healthcare. Are you finding that, given the opportunity, and if there were decent reimbursement rates, we would be able to attract more young people to serve lower income folks?

Mr. CATALANOTTO. Yes. There's no doubt. What I hear from the FQHCs is,

"Frank, you're sending the students to work for us. They are seeing the problem. They get a better appreciation of the needs of these kinds of patients, and they are going into those settings."

Yes, sir.

Senator SANDERS. Thank you very much.

Senator Franken has joined us, and I wanted Al to be able to give his opening remarks, if he'd like.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. There hasn't been testimony yet?

Senator SANDERS. Yes, everybody has testified, first round. But if you want to jump in and just——

Senator FRANKEN. Yes, I actually want to followup. Thank you, by the way, Mr. Chairman, for inviting me to attend this hearing. It's a very important hearing. And I want to pick up where you were on dental care.

In Minnesota, we became the first in the Nation to create a license for an advanced practice dental provider called a dental therapist. This was actually first started in the United States in Alaska to address the native population there, because in Alaska, to get a dentist, you would really only get a dentist once a year, who would fly in for a couple of days.

But now they have dental therapists. Other OECD countries have dental therapists. I guess the ones who are in Alaska were trained in New Zealand or something.

Dr. Catalanotto, in your written testimony, you emphasized the financial impact of the national dental care crisis, and you were just talking about the limited access to dental care and how it leads to wasteful spending. The GAO report released this morning notes that only 62 percent of Americans have dental coverage, and only about 40 percent of people have a dental visit in any given year.

You also noted in your testimony that one important way to expand access to dental care would be for States to consider dental therapists, like Minnesota. Could you elaborate on that? And what can we in Congress do to support the expansion of that program and the expansion of the number of dental therapists?

Mr. CATALANOTTO. Thank you, Senator. It's a great question. Just by way of background, I have been to Alaska three times, looking at the dental therapist model. I have talked extensively with the folks in Minnesota that have both trained these dental therapist and then employed these dental therapists.

Last week, I testified to the New Mexico legislature about dental therapists, and with me was one of the folks who employs dental therapists in Minnesota. I have read most of the literature on this. I am absolutely convinced that this is a cost-effective, safe, wonderful model to deliver care to people in need.

The beauty of dental therapists is that they can do the kinds of simpler procedures that a dentist might do, but that allows the dentists to work at the top of the scope of their practice instead of at the bottom of the scope of their practice. They are inexpensive to educate. They usually come from the communities they go back

to serve—underserved ethnic minority groups. They are a wonderful solution.

The difficulty comes from the opposition at the State level and then the national level, which I think was your question. At the State level, it's restrictive dental practice acts that forbid these individuals. There are approximately 15 to 20 States that are now this close to legislation to get dental therapists in their States.

But I would also add that it's not just dental therapists. These restrictive dental practice acts also prevent dental hygienists who are excellent at providing some of the primary services needed—these dental practice acts restrict them from working at the top of their skill across many States.

At the Federal level, the impediment that currently exists is that language was inserted into the health service reauthorization just a couple of years ago that prevents the first nation folks across this country who want to implement dental therapists—it prevents them from doing it because there's language that says they cannot use Federal funds. This is a travesty. This is an affront to the sovereignty of the first nations. That is something that you could do at the Federal level. There's not much you can do at the State level because of the individuality of dental practice acts.

Senator FRANKEN. I just think this is incredible.

Mr. Nycz, in Wisconsin, you would hire a dental therapist. Dental therapists, in studies, do the task they're allowed to do as well as dentists. Am I right?

Mr. NYCZ. Yes, that's what the evidence shows. But, again, because of these State laws, we do not have access. And, of course, there are not many of them that have been minted.

I'd like to circle back to the chairman's point about, "If you build it, they will come." The map that we showed shows that we're taking care of close to 100,000 people who have come from all over the State. And I would add that maybe 140 to 150 from the good State of Minnesota have come to us for dental care.

When we see people, when we open up a clinic—and this is why this is a little nuance—we get people with such horrible dental disease that young men and women just coming out of their dental training—many of them are kind of daunted by the task in front of them. We've had one dentist leave after 6 months, saying they're not prepared for this kind of work.

We had another dentist come and say, "You know, I'm not prepared for this." She went back and got a year residency, and now she's going to work for us starting October 1st. So there's a training aspect.

Dr. Michael McGinnis once wrote about the dirty dozen reasons why we don't do prevention. One of his points was the primacy of the rescue. So I would say as it relates to dental therapists that we have dentists who can't even do the job we put in from of them when they come right out of training, because they're not used to that.

But as a health center director, that's what we're faced with now, that primacy of the rescue. So I need well-trained dentists, trained even more than they get in their 4-year schools, to tackle that problem.

But I want to get over the top of that hill, and I want to have our population find that they can experience the same oral health level that more affluent people have. And it's at that time, as our population gets healthier, that we have a responsibility to the taxpayers as well. We've built group dentistry practices, with five dentists, 10 dentists, with hygienists.

And what I see over time is as our population gets healthier, we need to substitute in other providers who can handle the more routine things to allow our dentists to continue to handle and help out on those emergencies and the more complicated cases. So I see this more in our future, if these problems that we discussed can be resolved.

Senator SANDERS. Let me jump in.

Senator FRANKEN. I wanted to end on it, Mr. Chairman, if I might, because I have to go back to Judiciary. When we had testimony on this, we had a dental therapist who worked in a native village, in her own village. And she said that she was able to—because she had been from the village, when she would see kids in the village at the store or somewhere else, she'd say, "Brush your teeth every day."

So when you're talking about this prevention piece, I think that it's actually key that we have people who are more likely to go back to where they live. And I think that this is something I would really like to continue to pursue.

Thank you, Mr. Chairman.

Senator SANDERS. Thank you.

Let me pick up where Senator Franken left off. What we're really talking about is the workforce, in general, whether it's dental therapists or dentists or hygienists. And let me throw this out to Dr. Hughes.

What ideas do you have? Dr. Catalanotto made some suggestions, but is it your experience that we are not attracting the kind of practitioners that we need to take care of a population that has a whole lot of needs out there?

Mr. HUGHES. Actually, in Maryland, we have seen an increase in providers participating in Medicaid. We currently have over 1,600 providers. Our access issues deal more with adults not having coverage. And for those adults that do have Medicaid, the benefits are so limited that they cannot find a provider.

Senator SANDERS. So what happens to them?

Mr. HUGHES. They don't get seen.

Senator SANDERS. And when they're in pain, what happens to them?

Mr. HUGHES. They go to the emergency room, and then they are referred to the health department, and that's my other issue. There's not enough funding for public health infrastructure. Right now, I could easily have an adult program in the health department. But when there were budget cuts, one of the first things that was cut was the money for a dentist that was seeing the uninsured adult population.

So we don't have funding. We have the capacity, but we don't have funding. We don't have problems finding providers, but because we don't have the funding, we can't offer the services.

Senator SANDERS. Moving to what Ms. Stallings talked about. I think we have all seen pictures, whether it's healthcare or dental care, of doctors who volunteer their time, pro bono, to treating folks who don't have access.

Actually, one of my staff members, Erica—I think it was last year you were in southern Virginia—and, Ms. Stallings, you mentioned something similar—where it really looked like a third-world country or maybe a fourth-world country, where there were people who had terrible health and dental problems and couldn't find access to a doctor or dentist.

It was hard to believe that this was the United States of America, where people were spending the entire night, waiting in line in order to get a tooth extracted or get a basic checkup to find out whether they had cancer or whatever it may be. It really did not look like America.

Ms. Stallings, I gather you are familiar with that reality. Yes?

Ms. STALLINGS. Oh, yes, definitely.

Senator SANDERS. If you are a lower income American. You're on Medicaid, but you don't have access—Medicaid does not pay for a dentist. What happens to you? What do those people go through?

Ms. STALLINGS. We have an office. One day, I had a client who was in severe pain. I took her to our main office. We got her an appointment. I believe it was in a couple of days. And we were told that they would pay up to $200.

They have very limited funds, and, many times, the only option is clients waiting months on this waiting list to be able to be seen in the clinic where people are donating their time in their free off hours. But the wait list is incredibly long, and they have to wait for a long time often.

Senator SANDERS. So many of your clients are going through their days in pain.

Ms. STALLINGS. Well, it's more—when they're in severe pain, we definitely take action to get any treatment that we can possibly get. A lot of our clients do lose teeth, do have extractions, quite a few. If someone is really in pain, we try to do everything we can with the limited opportunities we have.

Senator SANDERS. Let me go back to anybody here.

Dr. Catalanotto, you raised this issue.

We have a crisis. We don't have the workforce to address the crisis. What role does the ADA, the American Dental Association, play in all this? And, by the way, we invited the ADA to be with us today, and they were going to be with us, but at the last minute they chose not to be here. Are they stepping up to the plate and addressing the issues that we're talking about today?

Mr. CATALANOTTO. In my opinion, in the last couple of years, there has been a shift in the national picture of the American Dental Association, in the leadership, and they are calling more and more attention to the access issue. But one of my arguments back to them would be, you need to lobby equally as hard for these access issues as you do for the business issues that concern you. I'm still not necessarily seeing that at this particular point.

The State level is totally different. The State organizations are very independent of the national organization. So one example would be the American Dental Association has policies on better li-

censing procedures. They support the policies that most dental education does. But at the State level, that's not particularly happening.

So easier reciprocity between the States is a national policy of the American Dental Association. It's still impeded in some States, but it is getting better. I want to be positive about that.

Senator SANDERS. Mr. Nycz, let me ask you a question. You guys are doing very well. I think we are doing well in Vermont as well in expanding access. If you had your druthers, have you done any computations as to what it would take in a State like Wisconsin—how many more facilities that you would need, how much more money you would require to provide, in a sense, universal dental care to the people in need?

Mr. NYCZ. It is a big number. Our State asked us could our State's health centers help them solve this problem, and how would we help them solve this problem. We said yes, if we stepped up and we had the resources, we could do that.

When Governor Doyle came to one of our ribbon cuttings, he said that the approach we're taking is building these group dental clinics. Many of my private sector dentist colleagues tell me that you're never going to solve the problem by trying to get a dentist to establish a practice in this town of 1,000 and this town of 300 and so forth. You need to really somehow centralize that, usually to the county seat or a place where people can come.

So that way, we can gain some efficiencies in a group practice kind of setting. It's easier to recruit and easier to retain. Governor Doyle said to me when he shook my hand,

> "I love this model. I'm wondering about how many of these we need. Could we have them within 50 miles apart so nobody goes more than 25 miles, or should it be 40 miles?"

When we simulated this, it does cost a lot of money to do this. I mean, we were up in the $100 million range. He was a former attorney general, and he just said, "Well, these folks, particularly the folks on Medicaid, have a legal right to these services, and we've got to find a way to do that."

We've made great progress, as that map shows. In my written testimony, I show what, collectively, we've done in the State of Wisconsin, and Wisconsin has been a wonderful partner to this day. But the fundamental question you're asking about cost—it is costly because we've neglected this, because we've had a population that does undervalue oral health and doesn't fully understand the importance of oral health to general health.

And we have the point that you made that around 42 percent, 43 percent visit a dentist every year. It should be more. In the model that we're trying to do—how do you capture savings? You can talk about people coming out of school with certain income targets and having to price things and all that. But the real savings on this is to raise the oral health profile of the American people.

The prevention potential in dentistry is gigantic. All of this stuff can be prevented. So we're engaged in this generational effort to try to make that difference. And places that could be helpful—we're grateful in Wisconsin that we have adult dental in Medicaid.

I've been saying, why don't all States have adult dental? Why don't we have adult dental in the exchanges? People say we can't

afford it. But then I ask back and say, "Well, how do we afford adult dermatology?" We have to totally change our thinking and integrate these things.

Senator SANDERS. You're absolutely right, and that's why we're holding hearings like this, just to raise that consciousness. And you made the point, which is true, that if you expand access to dental care, it is an expensive proposition. But if you don't expand access, it is an equally or perhaps more costly proposition.

Who wants to say a word about people walking into an emergency room and how much that costs?

Mr. CATALANOTTO. Senator, we did our own emergency room report in Florida. In 2010, 115,000 dental visits to the emergency room at a cost of $88 million. It prompted me to write an editorial. It was entitled, "Pay Me Now or Pay Me Later." We're paying for this. We are paying for this today, every day.

Just the Medicaid cost alone from that $88 million was approximately $30 million to $35 million. I did a rough calculation based on Florida Medicaid fees. I could have purchased 495,000 preventive visits, 495,000 preventive visits, rather than a wasted visit in a hospital emergency room where all they get is an antibiotic and pain medication, and they're told to go see a dentist tomorrow. Well, they can't find a dentist.

Senator SANDERS. Which is why they're there in the first place.

Mr. Nycz.

Mr. NYCZ. We're opening a clinic in Black River Falls, WI, on Ho-Chunk Nation land in a few weeks. The reason we're there is because 1,000 folks were leaving that community to go to our dental clinics in other communities. We are grateful for Federal funds through the Community Health Center Program, which you have something to say about, that got us money to help build and equip that center.

When we asked the public health department for a letter of support, they sent me a letter that said we have this 28-year-old—and this gets to the point that it's not just the Medicaid program, and it's one of the reasons why I think the health center model is so good. It's the leave-no-one-behind model.

A lot of this evolves into a talk about Medicaid. But as other panelists have pointed out, there are many people who don't have Medicaid, or they have Medicaid with no dental coverage, or they have health insurance with no dental coverage.

This 28-year-old who worked in the woods—no insurance, paycheck to paycheck, nothing in the bank—starts getting sicker and sicker and sicker. His sister starts to worry about him, and he's just going downhill. She's thinking he's got a job in the woods, so he must have Lyme disease.

They call the local clinic, and they say, "I'd like to make an appointment." "Does he have insurance?" "No." This is for physician care. They want a Lyme test. "Does he have any money for a down payment?" "No, he doesn't." "Well, we can't give him an appointment."

He gets worse. She takes him to the public health department. They go, "Oh, my goodness. We've got to get you right to the hospital." The hospital folks said he probably wouldn't have survived another 12 hours—advanced jaw cancer, three abscesses, sepsis.

He's alive today, thankfully. But how much money had to be spent in the system?

And what haunts me is in that letter of support at the end, they said, "Both his sister and I agree that had you had one of these dental clinics here, this would not have happened."

Senator SANDERS. What we know—and it's true of dental care and it's true of healthcare as well—is if a Medicaid patient needs primary care, can't find a primary healthcare provider and walks into an emergency room, it costs 10 times more than walking into a community health center. And I suspect the numbers are similar—but it's not even similar, because, as Dr. Catalanotto pointed out, the emergency room in a hospital, in most cases, doesn't really treat the dental problem as well, but just eases the pain and deals with the infection.

Let me get back to one other issue—and, Dr. Hughes, jump in if you want to here. The cost of dental school is kind of off the charts. I remember last year in Rutland, VT, talking to two young dentists. One of them had graduated from Tufts, I think—well over $200,000 in debt. What are we going to do about that?

Ms. HUGHES. How do we reduce dental school tuition?

Senator SANDERS. If I graduated with $200,000 in debt, I probably would not be running to a community health center to make whatever I would make there. I'd probably figure out how I'm going to make as much money as I possibly can. Is that a fair statement?

Ms. HUGHES. It is. However, if you work at the community health center, you're likely eligible for loan repayment. That's what we need to—I think it's important to establish more of these types of programs. In Prince George's County, we have a population of over 800,000 people. We only have one Federally Qualified Health Center and one Safety Net Clinic.

Senator SANDERS. That's all you have?

Ms. HUGHES. That's all we have. And there is only one dental shortage designation area in the county. So it is a daunting task to try to establish an area as a dental health shortage area, because it requires that you have surveys of all the dentists in the area and how they practice. That's hard information to get. They get a survey, and they toss it to the side. So we have to improve that process.

But I don't know how to answer that question, how we reduce dental school cost. It's costly to go to school. I mean, in dental school, we're doing procedures. There's the cost for the equipment. We're not just sitting in lecture halls. We're actually doing procedures. So that's why the cost is elevated.

Senator SANDERS. I want to get back to Dr. Catalanotto for a second. You raised an issue that we are familiar with, and that is the Sarrell situation in what, Alabama?

Mr. CATALANOTTO. Yes, in Alabama, sir.

Senator SANDERS. You see that as a potential model to provide cost-effective, quality dental care. Yes?

Mr. CATALANOTTO. Yes, I do.

Senator SANDERS. Say a few words about that.

Mr. CATALANOTTO. They've grown from 1 to 15 clinics in about 9 years with no grants, only on Medicaid fees. They do it because, first of all, the culture of caring. I can talk about that, but that's

not the business issue. The business issue is they run it with a ruthless business model. The CEO was a Fortune 500 company president at the age of 31. He did this as a volunteer activity in his community, but now it has turned into a major not-for-profit business.

Senator SANDERS. You're convinced the quality is good?

Mr. CATALANOTTO. I have been there three times. I have free rein to get up from my meeting and walk down the hall and walk into a clinic. Every time I walk in, the parent is in the room. Just before each visit, they take height, weight, blood pressure, and temperature and report it back to the parent.

I walk into the room and I see toothbrush—I don't see procedures being generated. I see prevention being emphasized. That's the only way they could have reduced care from over $300 to $125 annually.

But what do they do? They use their facilities 50 hours, 60 hours a week. They have mass purchasing power from 15 clinics, so they're able to get the most cost-effective pricing. They have a call center.

Senator SANDERS. And how do they pay their dentists, reasonably well?

Mr. CATALANOTTO. They pay their dentists very well, but not on production. The dentists are paid a straight salary, whether they do 15 amalgams or restorations in a day or whether they do five.

They use this interesting model. The call center staff may get a bonus for keeping the chairs filled, because they call their patients. They treat their patients with dignity. There's a common claim—oh, those Medicaid patients don't keep their appointments. Sarrell Dental Center has a chair utilization rate of 99 percent, because they treat their patients with dignity. They treat them with respect. They make them feel——

Senator SANDERS. You're telling me that they are making money?

Mr. CATALANOTTO. They are making money. Now, they're a not-for-profit, so they plow the money back into a new clinic. They just recently got themselves equipped to do some tele-dentistry. They do community service. They have great community outreach. Each clinic has a community person who goes out into the community, promoting care, promoting getting patients to go to the clinic and get their dental care. It's a wonderful model.

Senator SANDERS. And their staff feels good about working there?

Mr. CATALANOTTO. The staff feels good. So many of their dental assistants, for example, are college-educated young men and women because of the economic situation. They care. Sarrell has now started—there's just one or two—if you want to go to dental school, if you want to go to dental hygiene school, we will pay your way if you offer to come back and work here.

Senator SANDERS. So they're doing their own National Health Service Corps.

Mr. CATALANOTTO. They have their own National Health Service Corps. And I can tell you I'm on their board, unpaid, on their board of directors. They want to expand out of State. They are restricted from doing this because the CEO is an MBA.

Senator SANDERS. Mr. Nycz, is there anything in that model we can learn from?

Mr. NYCZ. I think health centers probably could learn from this model as well. But the task we're faced with, though, is not just taking care of Medicaid on dental. We have to contend with adults. We have to contend with people with psychiatric problems. We have to contend with people with disabilities. So we have to be a little bit more well-rounded.

For example, we could make our site more efficient if we didn't include large treatment rooms and wheelchair lifts. We could make our site more efficient perhaps if we didn't include space for training. So I think that we can learn from them, but their model is still fairly focused on a distinct population, and we have responsibility for everyone.

Senator SANDERS. Is Sarrell mostly focused on kids?

Mr. CATALANOTTO. It is only focused on kids because there are no adult benefits in the State of Alabama. So they only do children. He is absolutely right. It is a little different model. Now, they do some developmentally disabled. They have recently hired an oral surgeon. They have several pediatric dentists who can take children to the hospital.

Senator SANDERS. But only treating kids.

Mr. CATALANOTTO. But they only treat children through age 20.

Senator SANDERS. Let me just say to Mr. Nycz and to everybody here that we're going to do our best to focus more and more attention on this issue—why this hearing is so important. We're going to do our best to fight for more money for the community health centers.

We're going to take a look at the issue of dental therapists. We are going to take a look at models which seem to be high quality and cost-effective. We want to deal with that. I think your point about philanthropy is great, that it is not a solution to a major, major crisis in this country.

Dr. Hughes is here today, and she oversees the Deamonte Driver Dental Project. Maybe we'll conclude—Dr. Hughes, tell us—because some people may have forgotten—who Deamonte Driver is and why the project is named after him.

Ms. HUGHES. Deamonte Driver was the 12-year-old that died in Prince George's County from an abscess. His parent was unable to access dental care. His Medicaid had lapsed, and she could not find a dentist to treat the child. He was taken to an emergency room and given treatment for sinusitis and other things and released, and then was rushed back to the hospital and had to have immediate surgery when they found that the bacteria had spread to his brain.

Deamonte Driver died February 27, 2007. As a result, the Governor of Maryland said, "This cannot happen again." The Dental Action Committee was formed, and seven recommendations were made. Also, from their actions, the Deamonte Driver Project was initiated. It is a mobile dental unit that goes to Title I schools throughout the county. We treat all children, insured and uninsured.

One thing that we really don't talk about is the children that are uninsurable. We have a large population, in the county and in the

State, of children that are uninsurable, and we see those children as well.

By definition, a mobile unit in Maryland cannot be a dental home, and that is not our purpose. We work with families through case management to ensure that all children are in a dental home. We are there to treat emergent needs so that we don't have another Deamonte Driver.

As I talked about earlier, in our process, we are trying to establish statewide school screenings. Children are required when they go to school to have immunizations. Why are they not required to be seen by a dentist?

So in our demonstration project, we saw that there were a number—it was vital that we were there. There are a number of children who, had we not seen them, could possibly be Deamonte Drivers. So we honor the legacy of Deamonte Driver by being in the schools. We also provide treatment at the school he attended. The program has been very successful, and it is welcomed by all the schools that we attend.

Senator SANDERS. Dr. Hughes, thank you for the work that you do on that. I think to remember Deamonte Driver, our job is to dedicate ourselves to make very, very significant improvements to our dental care system so we never see another Deamonte Driver situation again in this country.

I want to thank you all, not only for being here today, but each in your own individual way for playing such an important role in addressing this issue. Thank you very much.

With that, let's adjourn the hearing.

[Whereupon, at 11:20 a.m., the hearing was adjourned.]

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