COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS

SUBCOMMITTEE ON PRIMARY HEALTH AND AGING

Dental Crisis in America:

The Need to Expand Access

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Thank you Senator Sanders, Senator Paul, and members of the subcommittee for holding this hearing today. My Name is Dr. Gregory Folse and it is with great joy that I come to you today as a provider of oral health services to the vulnerable populations who typically have poor access to dental care. I'm honored with the hope that by sharing the details of my life's work with you, we can better the lives of the patients I serve. On the ground, the truth for me about oral disease and poor access to dental care is clear and undeniable. Poor Children and Aged, Blind and Disabled adult Americans suffer needlessly with painful and infected teeth and gums and other unhealthy oral conditions. My staff and I have declared war on the oral diseases making our vulnerable patients suffer and we're dedicated to win it. I'm here to tell you we have helped them, we are helping them, and we will continue to help them. We also routinely help others to do the same.

This endeavor will require, however, assistance from each of you to make models like mine a replicable and viable professional choice for other providers.

So what are my models? I have two – one practice treating vulnerable nursing facility residents and another mobile school-based dental practice for Medicaid eligible children.

My Geriatric Model

In my geriatric model I personally provide comprehensive, portable, dental services in 24 nursing facilities to wonderful patients I consider to be God's children. I've developed Dental Director position in each facility. Without fancy equipment or the comforts of an office, I can and do provide services from simple denture adjustments to full mouth extractions and fillings. Patient autonomy and privacy, instrument sterilization, use of universal precautions, and care delivered to the same standards as in-office care can be, and are, achieved.

My practice staff includes two hygienists, one assisting with preliminary triage assessments and completing the facility's Minimum Data Set items on oral health for all residents while the other is dedicated to providing actual on-site hygiene services and facility staff education on prevention and provision of daily oral

hygiene services. They are invaluable professionals. Each have found and immediately referred to me patients in serious health crises, and have saved lives in the process. General supervision regulations in Louisiana, which allow hygienists to see patients without a dentist present, are critical to this model and help me insure patients get the care they need. Without general supervision, which fully enables a hygienist's abilities, I would not have a viable prevention model or the ability to provide my patients access to comprehensive care. Working with hygienists has increased the entry points of my patients into the dental delivery system. This is a wining model for my patients.

I do maintain a business office but no care is provided there. Two people man this ship, my office manager and my patient relations/billing manager. Both assist with normal office functions and facilitate obtaining informed consent for the patients I treat.

I travel with one trained dental assistant who assists with the treatment I provide. We have fun and do a lot of good.

All of my staff are god sent!!!

My Vulnerable Children Model

In my vulnerable children model, I employ 15 dentists, 18 expanded duty dental assistants, and an administrative service company to provide comprehensive dental services to children in schools. Since 2008, some 275 schools have requested services and to date my teams have treated over 20,000 children during 43,000 successful patient visits. We provide comprehensive services and do not "Cherry-Pick". With state of the art modern technology, fillings, stainless-steel crowns, x-rays, baby tooth root canals, and some extractions can be provided to the same standards as in an office setting. We refer children to specialists when needed just as you would in an office. Follow-up emergency care systems are in place as are emergency referral sites. I've formed partnerships with school-based health center nurses who assist me in emergency referrals as many families are extremely hard to reach by phone. It has been reported that

out of 1.6 million phone calls to families in the poorest sections of East Baton Rouge Parish school district only a 45% connection rate was achieved. These data prove the use of a written general informed consent form is the only way to assure access to the most vulnerable children – those whose parents can't be reached by phone.

Breaking the cycle of oral disease and neglect is, again, a major focus of my efforts for this population and oral health education is the only way to do it. We give each child dietary counseling, teach them about prevention of oral disease, and show them how to brush and floss. Additionally, these efforts ease the child into a caring and fun atmosphere which starts each visit off in a good way. The dentists who work for me are continually amazed at how well the children behave and accept treatment.

Historical Practice Data

In the old days (1992) when I started my nursing facility practice, 68% of my patients had no teeth and comprehensive dental services were only moderately in demand. As of September 2011, 80% have teeth, many more posterior teeth are present (harder to keep clean and to restore), and patients and their families are demanding preventive, restorative, surgical, and prosthetic services. The greater numbers of teeth present, coupled with the lack of dental care in the last season of life, have caused dental emergencies and oral cancer rates to sky-rocket in my practice. The tragic death of Deamonte Driver was not the first oral health death I've encountered. In my vulnerable adult dental practice I'm aware of many patients who have died and/or been sent to hospitals due to oral infections, sepsis caused from oral infections, and oral cancer. In 1995, I was involved with my first death due to oral disease patient, Ms. Mary. Others have unfortunately followed. The burden of disease present when a patient enters a nursing facility is profound. The lack of access to dental services between retirement and facility admission is certainly a contributing factor.

Conversely, I've provided life-saving dental treatment to many patients throughout the years who would have died without it. Treating serious infections, diagnosing oral lesions in time for them to be treated, and referring patients to specialists when needs exceed what I can do in facilities are all part of my routine. Oral disease found in vulnerable populations is, without a doubt, a life and death situation. I've seen it.

If there is one health care policy that enjoys almost universal support - and that's saying something in the contentious world of health care policy - it is that improving access to health care professionals is critical to improving health outcomes. Agreement on how to best achieve the policy goal of improving access, however, remains elusive. Fortunately, we now have empirical data sets from places like my home state of LA that affirm two important points: a) bringing oral health professionals to the patients works and b) there is no one delivery model that by itself can solve the access to care crisis. An absolute "all hands on deck" policy is needed to solve access to dental care in this great country. We need all the delivery models engaged, whether by mobile/portable services or within a bricks and mortar dental offices, or non-profit clinics regardless of which properly trained oral health professional is providing the care.

In LA we fought a ferocious battle, and used up a tremendous amount of energy, over the basic question of utilizing the mobile/school based model to increase access to underserved populations. Fortunately the need for access to dental care won the day due to a terrific alliance of health care professionals including federal qualified health clinics(FQHCs), school-based health centers, physician groups, hospital groups, churches, and advocates from across the state. The lesson learned is that the promotion of and use of Practice Administrators, general, written, informed consents, and portable/mobile dental services are all vital to oral health care reform if true access to dental care is to be achieved.

The Good News

This can be done! I'm a dentist with a traditional staff who has made a viable go of treating wonderful and needy vulnerable patients - the patients we are all here today to serve. To me they are God's children who greatly need and want what my staff and I provide. They value our services and I'm blessed to serve them. I don't hear "I don't like the dentist" like I used to. My patients line up and wait for me to arrive. Sometimes they give my simple things in appreciation: Ms. Tami tells me jokes, Ms. Pam made me a bracelet, Mr. George played a song for me on his guitar and Mrs. Bonnie gave me a piece of bread from her purse. Many can't speak or even thank me but those give me the most joy of all – the joy of being their doctor and doing what is best for them. I want others to know these joys so I travel around the country and teach others to do what I do. There are providers using my model, or parts of it, in 17 states now, and for that I am especially pleased. Another great joy for me is knowing that I've helped others to care for vulnerable populations, for treating them I feel is a gift from God.

As you will see not all the patients I serve have access to funding for care. I find it rewarding to donate services to them. Annually I routinely provide tens of thousands of dollars of donated services ranging from 10 to 16% of my gross production. Although donating services works for my patients and for me it is not the answer. Today's dentists and other dental care providers are burdened with significant debt. They need an infrastructure in place that will allow them to make a living while that debt is reduced. I will provide solutions to that problem later in my testimony.

A Day In The Life...

The need for surgical dental services in my practice is overwhelming. As of September 2011, my practice managed oral health services for 24 nursing facilities and some 2500 residents. Of those, 2,000 have natural teeth (are dentate) and of the 2000 dentate patients – 51% or roughly 1,000 needed extractions due to abscesses and/or severe gum disease. Specifically, 50% of dentate residents or 40% of the total resident population needed surgical care. Additionally, one must also consider the resident turnover rate of 30-40%. With

875 new patients per year and 51% needing surgical care I must manage an additional 430 new surgical patients/year. The total number of patients with surgical need equals 1430 residents per year.

I physically can't meet this overwhelming amount of need. But I try.

Additionally, the medical intricacies of this population are complex to say the least. Most patients present with multiple medical diagnoses and are taking a myriad of medications. Managing them pre and postoperatively is a daunting task requiring much time and effort. I'm honored and blessed, however, to do it.

Who Are Special Needs Patients?

To me, poor children, children and adults with intellectual and developmental disabilities, disabled adults, the aged, frail elders, medically compromised elders, and medically compromised adults are all Special Needs Patients. From a governmental perspective, however, they are defined as Medicaid eligible poor children and the Aged, Blind, and Disabled (ABD). For ABD adults oral health services are considered "optional".

It is societal sin to deny oral health services to the Aged, Blind, and Disabled adults. How is it right for a poor developmentally disabled child to loose dental benefits when they turn 21 years old? How is it right for a poor grandmother with no money to be denied treatment of dental infection? How is it right for a 45 year old man with intellectual disabilities and no family, who can't be treated in a traditional setting, to suffer with dental pain and have no hospital anesthesia services to cover his hospital needs?

I simply say "It isn't right".

Medicaid Facts - 2009

According to Medicaid and Chip Payment and Access Commission (MACPAC) report to congress dated March 2011, in 2009 62.2 million Medicaid eligible

existed and, of those, 17.4 million, or 28% were Aged and/or Disabled (AD). Amazingly to some, the total medical expenditures for only that AD population were $223 billion or 2/3 of the total Medicaid expenditures (plus Medicare expenditures). Specifically, 28% of the Medicaid population accounted for 66% of the total Medicaid expenditures. This doesn't surprise me at all. Half of these patients in my practice are infected, needing surgical intervention. Many live in pain and without my services would stay in pain. Their mouths teem with bacteria and disease. That bacteria gets into their bloodstream and lungs. That bacteria decreases their quality of life and often their lifespan.

Available Dental Benefits for the Aged, Blind, and Disabled Adult Population

So what is actually available? Medicare covers virtually nothing. Private insurance is very rare and the first to go at retirement age and in the 20 years of my geriatric practice I've had 8 patients with dental insurance. As already detailed, Medicaid benefits are optional to each state although Medicaid does cover prisoner oral health services, boil and bedsore treatments, any medical infection, and heck - Medicaid will even cover a penile implant. I doubt, however, the patients receiving these implants will ever get to kiss anyone with a mouth full of decayed teeth and gum disease.

Active Solutions #1 – IME Adjustments

A special dental access mechanism is available for nursing facility residents. Incurred Medical Expense regulations can help most nursing facility residents who are enrolled in Medicaid to pay for dental care. A great article entitled *How-to guide for IME* By Stacie Crozier, ADA News staff and a corresponding document *Incurred Medical Expenses* *Paying for Dental Care: A How-To Guide* were written and published by the ADA. To find the article go to http://www.ada.org/news/6295.aspx and for the document click on the word document on the first page of the article. The article gives the reader an understanding of the law and what IME can do whereas the document details

how to use IME adjustments form dental office, patient, and Medicaid Case Worker perspectives. In 20 years of practice no funding mechanism has allowed more access to dental care in my practice.

Unfortunately, IME adjustments are only allowed for Medicaid eligible nursing facility residents with a social security or pension income. Those without those income sources have no access to care through this system. Ironically, the most vulnerable residents, those who never worked like intellectually or developmentally disabled adults, have no funding for services though this system. I donate services to them routinely.

Active Solutions #2 - Special Care Dentistry Act

The Special Care Dentistry Act of 2010 is near and dear to me as it seeks to create a national Medicaid Infrastructure for ABD adults. The bill supports state Medicaid oral health services for ABD adults with federal dollars and is strongly supported by the dental profession and advocacy organizations across the country. If enacted no poor, vulnerable population will be left without of coverage and for the first time oral health services would be ensured for our most vulnerable adult population, Aged Blind, and Disabled Adults. With the rampant disease detailed in the ABD population, providing dental services to this population should prevent unnecessary medical procedures and expenditures. If passed, as infrastructure develops, and as the existing or new workforce is engaged we can better train the profession while the Aged, Blind, and Disabled get care. The bill ensures age appropriate procedures as well as deeming that oral health services are "medically necessary". Fiscally it makes sense too. The bill doesn't require coverage for the entire adult Medicaid population, a costly proposition, only the most vulnerable citizens within it.

For years I've heard "It'll Never, You'll Never, They'll Never, and We'll Never". I believe in this country and know that in my lifetime these patients will one day have the infrastructure for access to dental care that they so desperately need.

What Happened To Dental Education and Vulnerable Patient Treatment and Education?

Early in the 1980s Federal and State governments began cutting financial support to dental schools resulting in today's dental schools that must be self-funded. For schools to stay financially viable a significant amount of resources must come from the students and patient pools paying for dental services. Unfortunately, the most vulnerable Aged, Blind, and Disabled patients can't pay, dental schools can't see large numbers of them for free, and fewer are treated. Consequently, since the dental students don't treat them in large numbers, they aren't well trained and are uncomfortable treating the Aged, Blind and Disabled population. As tuitions rise the dental student debt has also risen rendering many dental students fighting to make ends meet upon graduation. This can obviously negatively impact their choice to treat vulnerable patient populations.

Oral Health/General Health Connections - CDC

Poor oral health means poor health to me. Although some describe how poor oral health is linked to many medical health problems I see it differently. You can't be healthy if you have poor oral health. There is no division of the terms in my mind. Infected teeth and gums are a significant detractor from quality of life. Patients of mine, especially disabled patients, suffer orally and those sufferings add to a host of medical complications such as the chance for infective endocarditis, sepsis, complicated diabetes ramifications, the risk of heart disease and stroke and stroke. Oral cancer is a significant killer with a horrible death rate. With regular oral exams oral cancers can be detected early when they are more easily treated. Unfortunately for my patients many haven't seen a dental provider in years and when my model finds a cancerous lesion it is rarely treatable. Death from oral cancer is a horrible death. I've seen it too many times.

Pneumonia and lung diseases are especially worrisome. A study, *Reservoir Of Respiratory Pathogens For Hospital-Acquired Pneumonia In Institutionalized Elders* by ALI A. EL-SOLH, MD, MPH, FCCP; et al detailed that of 46 patients in an ICU 28

had colonization of their dental plaques with pathogens known to cause pneumonia. Of those patients, 13 patients developed pneumonia. It was proven that 8 of the 13 patients had respiratory pathogens that matched genetically those recovered from their dental plaques. Over half of the patients in this study who got pneumonia got the bacteria that caused their pneumonia from their dental plaque. I have no doubt that providing preventive dental services to this population reduces the amount of oral bacterial and thereby should reduce the incidence of life threatening and costly pneumonia.

We all agree that bacteria in the lungs is bad and reducing the amount of oral bacterial is a primary must for aging and vulnerable patients. So who is a major front-line offensive and defensive player in my model? The dental hygienist. They help me keep my patients healthy through patient and staff education and providing preventive treatment. Unfortunately, without passage of a bill like the SCD Act, these services aren't covered for the most vulnerable ABD patients.

Practice Changing Innovations

I'd be remiss if I wouldn't mention several practice innovations that have significantly enhanced my ability to treat poor children and ABD adults. Physics Forceps, the Nomad hand-held x-ray machine, digital x-ray sensors, and portable dental units allowed me to provide a level of care I could have only dreamed of when I started my practice in 1992.

Respectively Submitted

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