United States Senate Committee on Health, Education, Labor and Pensions (HELP)
Subcommittee on Primary Health and Aging
September 12, 2013
Dirksen Senate office Building, SD-430

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% of low income seniors have not seen a dentist in over four years, primarily because of costs. Second, while we have made significant progress in improving access to care for children, there are about 48% of Medicaid enrolled children who are not receiving preventive dental services and about 77% 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% 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 dollars, 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 US. 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 nine year period from 2000-2008, 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 US 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% 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 that 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 US- 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 US 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 Medicaid 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, 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!

"Dental Crisis in America: The Need to Address Cost."

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Frank Catalanotto, DMD
Professor and Chair, Department of Community Dentistry and Behavioral Science
University of Florida College of Dentistry. fcatalanotto@dental.ufl.edu; 352-273-5970

Frank 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
  - 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
  - large scale not-for-profit models (e.g., Sarrell)
- Potential Solutions
  - insurance,
  - new workforce models
  - 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	Children	Children	Adults	Adults	Adults
	2000	2010	% Change	2000	2010	% Change
US overall	27%	41%*	53%	54%	48%*	**-10%**
* Note both still below 50%						

Adult Dental Care

- The decrease in adults seeking dental care cuts across economic groups with reductions in upper income, middle income and 6% 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% of all lower income older adults have not sought dental care in the last four 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 FY 2011.
Source: FY 2011 CMS-416 Reports.

REGION	Total children receiving a Preventive dental service	% Children receiving a Preventive Dental Service	Total children receiving a dental treatment service	% Children receiving a dental treatment service
US Overall	13,550,097	**42.2%**	7,466,214	**23.3%**

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% 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 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 recent 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 Website to learn more.

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

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

- 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]

Outcomes of hospitalizations attributed to periapical abscess from 2000 to 2008: a longitudinal trend analysis.

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

During the 9-year study period (2000-2008), a total of 61,439 hospitalizations were primarily attributed to dental/tooth infections in the US. **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.

Role of Dental Education

- 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 US
- **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 US 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

- 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**

* 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!

- 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.

- Doyle, Roger, **License to Work**, Scientific American, 296:2, February, 2007
- Kleiner,Morris and Kudrle, Robert, **Does Regulation Affect Economic Outcomes? The Case of Dentistry,** Journal of Law and Economics, 43:2, 547-582, October 2000
- Freund, Deborah and Shulman, Jay, **Regulation of the Professions: Results from Dentistry,** Advances in Health Care Economics and Health Services Research, 5:161-180, 1984

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

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.

New Workforce Models-Dental Therapists

- Recent studies/reports in the US 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.**

Sarrell Dental Centers of Alabama

- So, why not expand this model across the US?
- 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.