

Testimony from Diane E. Dimmock, RDH, MEd  
Connecticut Dental Hygienists' Association (CDHA) Legislative Chair  
American Dental Hygienists' Association (ADHA) Member  
Hartford Public Schools, Coordinator of Health Services

March 5, 2007

**Testimony to the Connecticut General Assembly, Public Health Committee  
In Support of  
Raised Bill No. 7069  
AN ACT CONCERNING ACCESS TO ORAL HEALTH CARE**

**Senator Handley, Representative Sayers and members of the Public Health Committee.**

My name is Diane Dimmock. I reside in Glastonbury, and am a constituent of Senator Handley. It is a pleasure to have this opportunity to speak to all of you today. I am the Coordinator of Health Services for the Hartford Public Schools, a Registered Dental Hygienist in the State of Connecticut, and the Legislative Chair for the Connecticut Dental Hygienists' Association. I have worked in Public Health School-Based Dentistry in the Hartford School District for the past 25 years. I am testifying in support of **Raised Bill 7069, AN ACT CONCERNING ACCESS TO ORAL HEALTH CARE**, which would raise dental reimbursement rates to the 70<sup>th</sup> percentile.

As the Coordinator of Health Services for the Hartford Public Schools (HPS) district, which has operated a comprehensive school-based dental program for the past 29 years, I can tell you that we struggle with budgetary constraints in the operations of our 15 school-based dental clinics, due to the inadequate Medicaid fees. There has not been an increase in fees in the past 13 years, while wages alone in the past 13 years have increased by a total of 55% - 65%. Currently there are few other options for our children to receive dental treatment, with our school-based dental services being a critical point of service for our children. In fact, it is not uncommon for our dental clinics to get phone calls daily requesting dental appointments for children as far away as lower Fairfield County. Annually, our clinics provide over 56,000 preventive and restorative dental procedures. Statistically, this program compares with the University of Connecticut as being the 2 major providers of pediatric dentistry in the Hartford area. It would be catastrophic if a program such as Hartford's school-based dental program were to close due to inability to fund its operation. With all costs rising annually, it has become a huge problem to continue to operate within the current fees. We have recently seen dramatic evidence of what lack of access can mean. The story this week out of Washington, DC is one of a 12-year-old boy who died on Sunday due to an infection from a tooth that spread to his brain. This child, like many others, could not find a dentist to care for him. It is clear that we need to address this crucial health care issue now.

Diane Elizabeth Dimmock, RDH, MEd  
Hartford Public Schools, Coordinator of Health Services  
960 Main Street, Hartford, CT 06103  
(860) 695-8793 fax: (860) 722-8630 (C) 860-462-0581 (H) 860-633-1794  
[ddimmock@hartfordschools.org](mailto:ddimmock@hartfordschools.org)

While CDHA and HPS fully and enthusiastically support **Raised Bill 7069**, the access crisis is a multifaceted one. While increased fees would enable the Hartford Public Schools to employ more dentists to provide more much-needed restorative care, it continues to be difficult to find dentists interested in public health dentistry. Ultimately, the fee increase will only address one aspect of the problem. The reality of fewer dentists both statewide and nationally in the next 10-15 years means the crisis will not be over. CDHA is proposing the creation of a public health Masters-prepared midlevel provider, which as been designed by the American Dental Hygienist Association. We are already familiar with midlevel providers exist in other areas – most notably as Nurse Practitioners. The advanced dental hygiene practitioner would be a cost-effective way of providing access to restorative dental treatment. I am including a comparison of what it costs to employ all levels of provider – Registered Dental Hygienist, Registered Nurses, Advanced Practice Registered Nurses (Nurse Practitioners), & Dentists. The chart is included here in my testimony. To summarize, it costs 38% more to employ a dentist than a midlevel provider. This cost-savings is impressive.

	2006/2007 Salary	% Inc. from RDH to Midlevel	% Inc. from Midlevel to DDS
RDH / RN	\$ 51,491	33.98%	
Midlevel / APRN	\$ 68,988		37.90%
Dentist / DMD / DDS	\$ 95,136		

***\* From Hartford Federation of School Health Professionals - Current Contract***

This would revolutionize public health dentistry when advanced dental hygiene practitioners are created, educated and employed in public health settings.

In closing, I want to urge this committee to pass **Raised Bill No. 7069**, while looking at some creative innovations that could truly bring access to care to our underserved children. And I want to thank you so much for this positive initiative toward increasing Medicaid reimbursement dental rates, and the other measures that will assist in impacting access to oral health care.

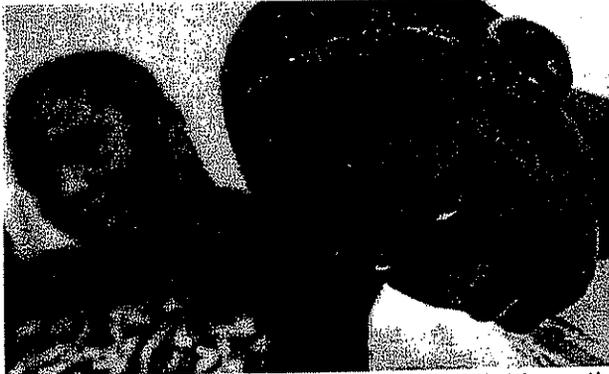
Thank you again!

Diane Elizabeth Dimmock, RDH, MEd  
Hartford Public Schools, Coordinator of Health Services  
960 Main Street, Hartford, CT 06103  
(860) 695-8793 fax: (860) 722-8630 (C) 860-462-0581 (H) 860-633-1794  
[ddimmock@hartfordschools.org](mailto:ddimmock@hartfordschools.org)



## For want of a dentist

Maryland boy, 12, dies after bacteria from tooth spread to his brain



Deamonte Driver, aged 12, is shown with his mother, Alyce, at Children's Hospital in Washington, D.C., after emergency brain surgery.

By Mary Otto

washingtonpost

Updated: 2:20 p.m. ET Feb 28, 2007

WASHINGTON - Twelve-year-old Deamonte Driver died of a toothache Sunday. A routine, \$80 tooth extraction might have saved him. If his mother had been insured. If his family had not lost its Medicaid. If Medicaid dentists weren't so hard to find. If his mother hadn't been focused on getting a dentist for his brother, who had six rotted teeth. By the time Deamonte's own aching tooth got any attention, the bacteria from the abscess had spread to his brain, doctors said. After two operations and more than six weeks of hospital care, the Prince George's County boy died.

Deamonte's death and the ultimate cost of his care, which could total more than \$250,000, underscore an often-overlooked concern in the debate over universal health coverage: dental care.

Some poor children have no dental coverage at all. Others travel three hours to find a dentist willing to take Medicaid patients and accept the incumbent paperwork. And some, including Deamonte's brother, get in for a tooth cleaning but have trouble securing an oral surgeon to fix deeper problems.

In spite of efforts to change the system, fewer than one in three children in Maryland's Medicaid program received any dental service at all in 2005, the latest year for which figures are available from the federal Centers for Medicare and Medicaid Services.

### **'They know there is a problem'**

The figures were worse elsewhere in the region. In the District, 29.3 percent got treatment, and in Virginia, 24.3 percent were treated, although all three jurisdictions say they have done a better job reaching children in recent years.

"I certainly hope the state agencies responsible for making sure these children have dental care take note so that Deamonte didn't die in vain," said Laurie Norris, a lawyer for the Baltimore-based Public Justice Center who tried to help the Driver family. "They know there is a problem, and they have not devoted adequate resources to solving it."

Maryland officials emphasize that the delivery of basic care has improved greatly since 1997, when the state instituted a managed care program, and in 1998, when legislation that provided more money and set standards for access to dental care for poor children was enacted.

About 900 of the state's 5,500 dentists accept Medicaid patients, said Arthur Fridley, last year's president of the Maryland State Dental Association. Referring patients to specialists can be particularly difficult.

Fewer than 16 percent of Maryland's Medicaid children received restorative services -- such as filling cavities -- in 2005, the most recent year for which figures are available.

For families such as the Drivers, the systemic problems are compounded by personal obstacles: lack of transportation, bouts of homelessness, erratic telephone and mail service.

The Driver children have never received routine dental attention, said their mother, Alyce Driver. The bakery, construction and home health-care jobs she has held have not provided insurance. The children's Medicaid coverage had temporarily lapsed at the time Deamonte was hospitalized. And even with Medicaid's promise of dental care, the problem, she said, was finding it.

When Deamonte got sick, his mother had not realized that his tooth had been bothering him. Instead, she was focusing on his younger brother, 10-year-old DaShawn, who "complains about his teeth all the time," she said.

DaShawn saw a dentist a couple of years ago, but the dentist discontinued the treatments, she said, after the boy squirmed too much in the chair. Then the family went through a crisis and spent some time in an Adelphi homeless shelter. From there, three of Driver's sons went to stay with their grandparents in a two-bedroom mobile home in Clinton.

By September, several of DaShawn's teeth had become abscessed. Driver began making calls about the boy's coverage but grew frustrated. She turned to Norris, who was working with homeless families in Prince George's.

Norris and her staff also ran into barriers: They said they made more than two dozen calls before reaching an official at the Driver family's Medicaid provider and a state supervising nurse who he On Oct. 5, DaShawn saw Arthur Fridley, who cleaned the boy's teeth, took an X-ray and referred him to an oral surgeon. But the surgeon could not see him until Nov. 21, and that would be only for a consultation. Driver said she learned that DaShawn would need six teeth extracted and made an appointment for the earliest date available: Jan. 16.

But she had to cancel after learning Jan. 8 that the children had lost their Medicaid coverage a month earlier. She suspects that the paperwork to confirm their eligibility was mailed to the shelter in Adelphi, where they no longer live.

It was on Jan. 11 that Deamonte came home from school complaining of a headache. At Southern Maryland Hospital Center, his mother said, he got medicine for a headache, sinusitis and a dental abscess. But the next day, he was much sicker.

Eventually, he was rushed to Children's Hospital, where he underwent emergency brain surgery. He began to have seizures and had a second operation. The problem tooth was extracted.

### **Deamonte appeared to be mending slowly**

After more than two weeks of care at Children's Hospital, the Clinton seventh-grader began undergoing six weeks of additional medical treatment as well as physical and occupational therapy at another hospital. He seemed to be mending slowly, doing math problems and enjoying visits with his brothers and teachers from his school, the Foundation School in Largo.

On Saturday, their last day together, Deamonte refused to eat but otherwise appeared happy, his mother said. They played cards and watched a show on television, lying together in his hospital bed. But after she left him that evening, he called her.

"Make sure you pray before you go to sleep," he told her.

The next morning at about 6, she got another call, this time from the boy's grandmother. Deamonte was unresponsive. She rushed back to the hospital.

"When I got there, my baby was gone," recounted the mother.

She said doctors are still not sure what happened to her son. His death certificate listed two conditions associated with brain infections: "meningoencephalitis" and "subdural empyema."

In spite of such modern innovations as the fluoridation of drinking water, tooth decay is still the single most common childhood disease nationwide, five times as common as asthma, experts say. Poor children are more than twice as likely to have cavities as their more affluent peers, research shows, but far less likely to get treatment.

Serious and costly medical consequences are "not uncommon," said Norman Tinanoff, chief of pediatric dentistry at the University of Maryland Dental School in Baltimore. For instance, Deamonte's bill for two weeks at Children's alone was expected to be between \$200,000 and \$250,000.

The federal government requires states to provide oral health services to children through Medicaid programs, but the shortage of dentists who will treat indigent patients remains a major barrier to care, according to the National Conference of State Legislatures.

Access is worst in rural areas, where some families travel hours for dental care, Tinanoff said. In the Maryland General Assembly this year, lawmakers are considering a bill that would set aside \$2 million a year for the next three years to expand public clinics where dental care remains a rarity for the poor.

Providing such access, Tinanoff and others said, eventually pays for itself, sparing children the pain and expense of a medical crisis.

Reimbursement rates for dentists remain low nationally, although Maryland, Virginia and the District have increased their rates in recent years.

Dentists also cite administrative frustrations dealing with the Medicaid bureaucracy and the difficulties of serving poor, often transient patients, a study by the state legislatures conference found.

"Whatever we've got is broke," Fridley said. "It has nothing to do with access to care for these children."