Sedation Dentistry

Good morning. My name is Nick Rogers and I am a full time practicing general dentist in Arkansas City, Kansas since 1979. Today I am speaking on behalf of the Kansas Dental Association and myself. I first want to thank you for taking the time out of your busy schedules to learn about sedation dentistry and two groups of individuals that have difficulty in accessing dental care.

Before I begin my testimony, I want to explain that the subject of access to dental care for special needs patients and pediatric patients with and without special needs is complicated because there is no one size fits all solutions. Each case, each treatment presents special challenges for each dentist, assistant and treatment facility. Our hope is that our testimony will make you aware that these very vulnerable people have challenges that we cannot treat without help. While it may sound like we are asking for money…it's not for us. It's to enable us to find solutions for the patients handicapped in ways that make traditional treatment impossible; it's to allow us to work in hospitals and in our offices with the necessary staff and equipment; it's to allow us to have options to keep these medically fragile patients safe. These testimonies are not about greed; not about "wish lists" for our office; not about making any of us rich. These testimonies are presenting real challenges in the treatment for real people…many unable to speak for themselves; many unable to comprehend their own needs. These are people we are challenged to treat and there are many more unable to find dentists with the right equipment or training to be treated. We are seeking help to get equitable reimbursement for ourselves and for the hospitals that allow us to use their operating rooms and staff.

With the understanding that the Chair is particularly interested in access issues as well as innovations regarding Sedation Dentistry and the special needs population, I will address the two populations that have the greatest obstacles in access to dental care and why.

With that said, today's objectives are:

- Our practice and who we are
- Define two groups that have high needs for sedation dentistry
- All children (including children with special needs) with Severe Early Childhood Caries (cavities)
- Special Health Care Needs Patients (SHCN), Especially adults
- The Problem and the Dilemma
- Sedation Dentistry – Definition and Types
- Transfer of Helpful Information

- Facility Considerations
- "The 800 Pound Gorilla" – Finances

Who I am

First, a little about our office. There are 4 dentists in our practice, 4.5 hygienists, 10 assistants of which 2 are translators, and 3 front office personnel. Our practice is completely open to Medicaid patients who are under 21 years of age and special health care needs adults within our community, which I loosely define as Cowley County. We do not accept Medicaid on special needs patients over the age of 21 outside our community or any adult Medicaid (with exceptions) due to financial reasons which I will expand upon later in my presentation.

We are located in southcentral Kansas on the Oklahoma border, an hour south of Wichita, 3 1/3 hours from Kansas City and about 2.5 hours from Oklahoma City.

We are located in Cowley County, the second largest geographic county in the state with a population of about 35,000. There are two main cities of similar sizes, each about 12,500 people. Winfield is the county seat and Arkansas City, to the south, the home of Cowley County Community College.

We are a blue-collar, lower socio-economic community with both cities being below the state income average and Arkansas City with the largest amount of poverty.

My involvement in access to care includes Head Start, in which our practice provides care to all Head Start children in our community regardless of their ability to pay. Our office partners with KDHE in their school screening and sealant program, provide dental care to the patients of our local FQHC (safety net clinic) on a contractual basis. I have served as past president of the American Academy of Pediatric Dentistry Foundation which gives financial support to organizations within local communities that provide dental care for those children that cannot afford dental care. I am also an active member of Oral Health Kansas, have served as Region VII Head Start Oral Health Consultant as a part of the American Academy of Pediatric Dentistry/Office of Head Start Initiative for the states of Kansas, Missouri, Iowa and Nebraska as well as other dental activities both on the state and national level. I am currently serving on the American Dental Association's Council on Advocacy, Access and Prevention.

What is the sedation dentistry?

Sedation dentistry helps patients feel calm, relaxed and at ease during dental procedures. It's a moderate level of sedation, so patients are technically awake but feeling very carefree. It's sometimes called conscious sedation dentistry or "twilight sleep" because it creates a state of short-term amnesia (forgetfulness) where patients experience insensitivity to pain without the loss of consciousness.

Why do we use sedation dentistry?

People of all ages can benefit from sedation dentistry, including children. Dentists often recommend this option for those with:

- Dental anxiety
- Young children that are “Pre-Cooperative”
- A fear of visiting the dentist.
- An overly sensitive gag reflex.
- A fear of needles (aichmophobia).
- Extreme teeth sensitivity.
- Feelings of claustrophobia while in the dental chair.
- Decreased sensitivity to local anesthesia.
- Difficulty controlling movements.
- Special needs (including physical, cognitive or behavioral).

What types of sedation are used in dentistry?

There are varying levels of sedation dentistry based on the unique needs of each patient. Factors include the level of anxiety, the length of the procedure, the **health history** and personal preferences. The most common types of sedation dentistry include nitrous oxide, oral conscious sedation and intravenous (IV) sedation.

Nitrous oxide

Nitrous oxide is commonly known as “laughing gas” which is inhaled through a mask or nosepiece, and calming effects begin within three to five minutes. The dentist controls the amount of sedation patients receive and adjusts dosages accordingly throughout the procedure. Once treatment is over, the dentist gives patients pure oxygen to flush the nitrous oxide out of the patient’s system. Because the laughing gas leaves your system so quickly, patients are able to drive themselves home after the procedure.

Oral conscious sedation

With oral conscious sedation, the dentist gives a sedative medication (usually in pill form) about an hour before your procedure begins. Most dentists use triazolam (Halcion®), which is in the diazepam (Valium®) family. Other dentists might use other medications, too, including zaleplon and lorazepam. Dentists often used liquid sedation in pediatric dentistry, such as midazolam oral syrup.

Oral sedation makes patients quite groggy, and they may even fall asleep. Some may still be able to communicate with the dentist if necessary, and will awaken with a gentle nudge. Because oral sedation temporarily affects memory and motor skills, a friend or family member is needed to drive patients home after the procedure. This takes much time to administer and often does not

sedate a person deep enough to make the experience comfortable for many. It is usually used for shorter appointments and does not always work well for adult special needs patients. The results are very unpredictable. In Kansas, this requires a Level I Sedation permit if the dentist is administering the medications.

Intravenous (IV) sedation

IV sedation dentistry is the deepest form of conscious sedation available in a dental office setting. The healthcare provider delivers sedative medications directly to the bloodstream through an IV line. This is most commonly administered by a CRNA (certified registered nurse anesthetist). During the procedure, your CRNA monitors heart rate, blood pressure and oxygen levels. They can adjust the dosage at any point and can use reversal medications if necessary. Most people who receive IV sedation dentistry fall asleep and have little to no memory of their treatment when they wake up. This option is best for people with severe dental anxiety or those who are undergoing lengthy procedures. This requires a Level II or Level III sedation permit depending upon the depth of sedation if the dentist is administering the medications.

Is general anesthesia ever used in dentistry?

In some most cases general anesthesia in a hospital or ambulatory surgery center may be necessary when treating young children, adults with special needs or people with severe dental anxiety. General anesthesia is a type of **unconscious** sedation. In other words, you'll be completely unconscious during the procedure. General anesthesia, in most cases, is provided by the anesthesia team at the hospital, either an anesthesiologist or CRNA.

The types of sedation used in my office are nitrous oxide and deep conscious sedation (IV sedation) administered by a trained CRNA. I had a Level I sedation permit, but I let it lapse since oral conscious sedation was not very effective or predictable. Also, by using a CRNA to administer and monitor sedation, I can concentrate and give attention to the dental care. In general, with the exception of oral surgeons, dentistry is going away from the model of the same person providing the sedation and, simultaneously, performing the dental treatment.

The two groups of the population that have the greatest access to care as well as the greatest need for sedation/hospital dentistry are some children that have severe dental needs, most from lower socio-economic families and minority populations. The other group would be patients with special needs, both adult and pediatric, but particularly, adults with special needs.

Children with Severe Early Childhood Cavities

I will begin with the children from lower socio-economic levels first. Young children from lower socio-economic levels and those children of minorities are at risk for severe early childhood caries. The definition of severe early childhood caries for children younger than 3 years of age is any sign of smooth-surface cavity and for a child between the ages of three and five it is one or more cavities.

Cavities affect the general population, but they disproportionately affect low-income, American Indian, Latino, and African American children. According to the Center for Disease Control and Prevention (CDC), in the United States, children from low-income families are **twice as likely to have cavities** than children from higher-income households. They also have the most difficulty finding dental care. The population that I serve falls within that lower income group. Our school system has over 70% of its students on the free and reduced lunch program which means most all of them are on the Medicaid program. We have 32% Hispanic and 3% Native American, the two ethnic groups that nationally have the highest severe early childhood cavities (S-ECC) and have the least access to dental care.

Head Start programs are required to meet different performance standards of which one is oral health. Children with toothaches cannot learn. To quote a Head Start director, "No one will see our kids. Most general dentists do not want to see young children and even if they are willing to see young children, most students can only pay with a Medicaid card and no one will accept Medicaid." This is not unique to Head Start children as the same can be said with any child with a Medicaid card.

In my practice, it is not uncommon to see children under 5 with 12 -20 out of 20 teeth that need restorations. For children with this many cavities and at their young age, sedation, if not general anesthetic in a hospital setting, is needed to provide the dental care needed. Most general dentists do not have the skills of a pediatric dentist or have the partnerships to treat these children, particularly in rural areas. In general, pediatric dentists are most often not located in rural areas.

Adult SHCN Patients

I would like to devote the majority of my presentation to the adult special health care need population. Adults with special health care needs (SHCN) face difficulty obtaining health care services when compared to the general population. **Dental care is the most prominent unmet health care need among this population.** There are multiple reasons for this:

1. There are not enough dentists willing and able to treat patients with SHCN.
2. Patients with SHCN experience increased barriers to care (e.g., physical, financial, geographic).
3. Families and caregivers of patients with SHCN have more difficulty facilitating dental care.
4. Pediatric dentists have increased training for the provision of care of patients with SHCN. However, adult patients with SHCN have an adult dentition and adult dental needs. The scope of care that pediatric dentists can provide does not include many of the adult dental care services that general dentists provide.

In Cowley County, we have a disproportionately large number of patients with special needs, both children and adults. This is due to the 1998 closure of the state hospital in Winfield, Kansas, as a result of the Kansas Developmental Disabilities Act of 1995. The residents now live within our community and unfortunately the funds and the services that they had within the hospital did not follow them out into the community. The hospital had a full-time dentist and physician that could coordinate care for the residents. Now that they live within our community, many have

difficulty receiving dental services due to financial considerations and many require sedation, if not general anesthetic within a hospital setting to receive dental treatment. For persons with special needs, this is a huge problem within the state.

Persons with special needs are referred to our office from as far away as Garden City which is about a 4 ½ hour drive. We have a large population that we provide dental treatment for from the Wichita, Salina and Emporia area. We have a special arrangement with one facility in El Dorado, about an hour away, in which we are the main provider of dental care. Grace Med, a large FQHC in Wichita refers those that need general anesthesia in a hospital setting to our office along with some other dental clinics within the Wichita area. There are some of the pediatric dentists that refer adult special needs patients to our office because as the patient becomes an adult, the pediatric dentist no longer offers the services needed by some adults. In short, there is an incredible unmet need for adult persons with special needs to find dental treatment.

What is the definition of Special Needs?

The American Academy of Pediatric Dentistry (AAPD) defines special health care needs (SHCN) as any condition that limits or impairs a person physically, developmentally, mentally, cognitively, emotionally, behaviorally, or sensorially. These conditions can be congenital, developmental, or acquired through disease, trauma, or environmental causes. They can make it difficult to perform daily self-maintenance activities or significantly limit major life activities. People with SHCN may require medical management, health care intervention, or specialized services or programs.

How Many Persons have a disability?

Nationally there are 50 million people with disabilities. 5 million with seizure disorders, 700,000 with cerebral palsy, 7 million with intellectual disability and 10+ million children with SHCN.

In Kansas, there are 637,775 persons with disabilities according to the CDC.

The Problem:

- Pediatric dentists are the primary source of oral health care for SHCN children and for **many over age 21**
- 95% of pediatric dentists provide treatment for SHCN children as they receive the training within their residency for this population.
- Nationally, 750,000 adolescents reach adulthood each year.
- Dental needs of adults transcend skills of pediatric dentists
- Only 10% of general dentists treat SHCN adults, which I will expound upon later in my presentation.

The Dilemma:

Pediatric dentists are the primary source of oral health care for SHCN children**,** but once they become adults, the pediatric dentist does not have a general dentist in which to refer them.

Key Words in Treating Persons with Special Needs

Adaptability - Many procedures are not able to be performed for a person with special needs in the normal manner in many cases. Sometimes alternative materials need to be used. Other times, we need to adjust our delivery because the patient is not mobile when they are in a wheelchair. Due to transportation issues, patients do not always arrive as scheduled. There are various other reasons as well.

Empathy and Caring – The staff treats the person with respect and a caring attitude. They do not feel sorry for the patient, but they do show empathy.

Communication – Learning as much about the patient **in advance** of the appointment is critical. Some patients are their own guardian while others have someone who has the power of attorney for them.

The Golden Rule!

Appearance is deceiving so do not prejudge the patient. I had one patient with Aspergers' Syndrome with other complications and was sitting leaning forward in a wheel chair. He looked as if he had an intellectual disability, but instead was quite the opposite. As I began to speak to him, he asked "why are you was using "baby talk" when speak to me. I am not stupid". When I looked down, he was holding a novel that he was reading.

Each SHCN patient is unique. If you have seen one SHCN patient, you have seen one special health care needs patient because each one has unique and often complicated challenges. Many, if not most, have multiple diagnosis and many of the diagnosis are on a spectrum. There is not any one defined treatment protocol for any one SHCN adult with similar diagnosis as they are all different and have different personalities. Determining the dental needs of many of the SHCN as well as the proper treatment setting (i.e. sedation, and if so, what kind or a traditional office setting) is important in advance of the appointment

Dental Care Passport

Due to the distance many travel, we do not have the opportunity to examine them prior to the appointment and even if we did, many of those that we see will not allow a through, or sometimes, even superficial exam. I have done exams in the backseat of the car in our parking lot as the patient would not enter the building. In advance of the patient arrival, we send out a form in an effort to assess the patient's needs and learn about the person in advance so that we can choose the correct treatment setting. The form that we use is called the "Dental Care Passport" developed by Oral Health Kansas. It asks questions concerning the patient's personal data,

medical history, dental history, mobility, communications/behavior and sensitivities. (https://www.oralhealthkansas.org/DentalPassport.html)

Treatment Settings

In my office, there are three different treatment settings that we can offer SHCN patients.

Traditional Office Setting

The majority of our SHCN patients are seen within our office although we have made some modifications to make the visits more successful. The advantages of seeing the SHCN patient within our office is that it is the safest delivery of dental treatment, does not interrupt the entire day and it is the most efficient.

First and foremost, our office is ADA compliant. We have also made the entrances into the operatories wide enough to accommodate wheel chairs and the motorized chairs. Loud noises and other persons in the reception room can be a deterrent for many types of disabilities such as Autism. We therefore do our best to schedule the patients so that they bypass the reception room and are guided directly to the treatment room. We have one isolated room with a solid door that we have made into a sensory room for those that need a more isolated, quiet environment. It has low lighting, mild oscillating lighting, television on the ceiling, weighted blankets as well as a weighted stuffed animal. We also offer noise cancelling headphones. We do our best to keep the same staff members with the same patient each visit.

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Be Adaptable

The key word in seeing special needs patients is adaptability. Identify the goals in advance. In many recall cases, we know that we will not be able to do all their treatment ideally each visit. It is understood that we will clean the teeth the best that we can, check for cavities, maybe monitor other conditions in many of the cases. Our goal is to keep everything in check as long as possible

until we have to sedate the patient. This minimizes the number of times each patient is taken to the hospital or, if possible, deeply sedated with in out office.

In some cases, the patient's tolerance diminishes and our treatment plan has to change in a moment. The difficult challenge for a general dentist is to use critical thinking skills to do the best treatment for a patient with the resources that the patient has and within their tolerance. It is not always possible to perform the ideal treatment and many times, that leaves me feeling guilty. In dental school I was taught to do the most ideal dental treatment, but I was not taught to make the best compromises with the resources presented; i.e. to use critical thinking skills.

Also, one has to be adaptable in the positioning the patient and using the adjunct items to make the visit easier for the patient. This patient has Asperger's Syndrome. He is a very bright individual and knows his limitations. He brings his own physical constraint equipment with him and instructs how to use them for his maximum comfort. I always wonder what the people in the reception room think when he brings this equipment back through the reception room.

In Office Deep Sedation.

The deep sedation within our office is always administered by a CRNA. He/she brings in the necessary monitoring equipment and administers the sedation. Oxygen is plumbed into our office and the operatory which allows for a flowmeter to administer the oxygen.

The advantages of this are that we are working within our same surroundings and with the equipment that we use for all patients. It offers more flexibility in our treatment selections and administratively, it is less of a burden as compared to treatment within the hospital and admission to the hospital.

Most commonly the patients scheduled for this are ASA I and ASA II patients, children over the age of 3 needing sedation and those who are mild to moderately Autistic. A medical health and physical (H&P) are required within a year and a BMI less than 36. We are usually scheduled for in office sedation 2 months out and we schedule up to 6 patients on those days depending on the needs of the patients.

Some of the MCOs (Managed Care Organizations) have changed their plans to a plan called "Dual Complete". Since that plan was put into place last fall, there is very little reimbursement for the CRNA to administer the sedation in our office setting, so now, those patients are seen in the hospital setting. It is much more cumbersome and in the long run, much more expensive. Grace Med in Wichita refers many of these patients to us.

Hospital

The hospital is the most administratively difficult. We use the hospital for dental procedures for all children under 3 needing sedation. If in office sedation fails medically compromised (which many of the more severe SHCN patients are), patients with high BMI, airway issues such as many Down Syndrome patients we will use the hospital. Some insurances will pay for the hospital and not for in office sedation. The majority of special needs patient that we see, are seen

in the hospital because they are too medically complex for deep office sedation and their appointments are usually longer.

I perform hospital cases on my day off since the money generated by hospital cases is far less than a regular scheduled day of production at my office would generate. We schedule 2-4 patients on an average hospital day. If we have never seen the patients before, such as a SHNC adult patient, we estimate how much work is needed so therefore we only schedule 2 per day. On some of the patients that we have not previously seen before, the cases can be as long as 3.5 hours. We are scheduled out 3-4 months.

I have hospital privileges in two rural hospitals. The hospital that I have used for years, South Central Kansas Medical Center, was an acute care hospital. In an effort to financially survive, it was the first hospital in Kansas to reclassify itself to a “Rural Emergency Hospital”. When the status was changed, many of their support services were removed which made it impossible for me to see some of the more medically complex patients. I therefore applied for hospital privileges at William Newton Memorial Hospital in Winfield which is a “Critical Access Hospital”.

It is difficult for dentists to get surgery time in many hospitals. Until recently, last September, hospitals received no facility fee from Medicaid, Medicare or from most private insurances since there was no billing code from CMS for dental procedures within the hospital. Therefore, hospitals were providing their surgery rooms for no reimbursement when it was used for dental procedures. It was for that reason that many pediatric dentists, oral surgeons and general dentists were being denied access to hospitals. Last fall, several dental organizations (AAPD, ADA and AAMOS) successfully lobbied CMS to develop a code and reimbursement structure for dental procedures within surgery. The Kansas State Medicaid Director adopted the code so now hospitals within Kansas are reimbursed about $1750 as a facility fee when the surgery room is used for dental procedures. Although this code is accepted by Medicare and Medicaid, some private insurances have yet to adopt it. Even with that, most dental procedures take longer, average being about 1-4 hours, and have a facility fee that is much less reimbursement as compared to other surgery room procedures such as ear tubes for the ENT who can do multiple procedures at a higher facility fee reimbursement in the same time that it takes a dentist to do one case. Therefore, access to many surgery rooms for dental procedures is still difficult for many dentists.

In addition to a small facility fee to the hospital, many times additional personnel need to be added due to the increased patient management issues. Also, with many cases, there is much more time involved by the hospital staff both, in pre-operative as well as post operative, for management issues. In a few cases, the patient needs to be kept overnight for observation before dismissal.

In the case pictured here, it took about 50 minutes to get this patient from the pre-operative area to the surgery room due to patient management challenges.

Paper Work

In addition to the time involved in the actual dental treatment, there is much time consumed administratively in preparation for a hospital case. When someone calls our office for sedation services, The hospital coordinator in our office gets a brief description from the caller to learn about the patient and their background. She visits with them about the process and the finances. If they want to move forward with treatment, she sends them a letter along with our patient packet and the dental passport. That letter reiterates the information discussed on the phone. Once all documentation is back, she gives it to me to review. Once I have reviewed the information, she forwards it to whichever organization (ASA, WNH, SCKMC) so that I can review the information with the anesthesia team or the CRNA. Once the facility approves the case, the parents are sent the final paperwork and services are scheduled. Between scheduling a surgery date and the actual surgery date, our office coordinator must confirm that we have all clearances from the doctor and/or any specialist. If it is a hospital case, she confirms that the H&P is scheduled in the correct time frame. Pre-admits are sent to the facility where they are work on insurance clearance for the medical side and coordinate the schedule for the surgery day. This includes, once again reviewing the H&P and making the pre-op calls. This is all accomplished before the actual surgery date and requires hours of work carefully coordinating treatment plans with great attention to detail.

Hospital Equipment

Hospital Dentistry is the least efficient and least cost affective as we have to physically bring all of our equipment to the hospital.

On a typical hospital day that we see 3 patients, I awake at 5:30, go to office to load the equipment and supplies into my truck, arrive at the hospital by 6:30 and we are in the mouth at 7:00. I bring two dental assistants with me that have hospital clearance and they are paid time and a half for the hospital assignment. When we are finished, we pack up all of our equipment, return to the office and sterilize the equipment. Write up our chart notes and send them to the hospital. Depending on the day, we finish anywhere from noon to 3:00 and have not had lunch.

The hospital does not have any dental equipment. It requires our office to purchase a delivery system (a piece of equipment to run the “drills”) at a cost of about $6500, a hand-held X-Ray machine (about $7000), 2 digital sensors for the X-Ray (cost about $21,000), Ultrasonic cleaning equipment ($3500), a computer to read the X-Rays, hand instruments and disposable supplies. We leave the dental unit at the hospital, but bring all else.

Coordination of Services

When we bring a patient to the hospital for general anesthesia, we try to coordinate other medical procedures to be performed simultaneously with our dental treatment to minimize the number of general anesthesia exposures. If possible, we coordinate with the patient’s physician to allow other needed medical treatment for the patient that may not be able to be provided in a normal physician’s office because of the lack of the patient’s tolerance. The physician or nurse often does blood work, cleans ears, remove tumors or any other medical services. There is a

reimbursement disincentive to combine different procedures in the same appointment so it is becoming more difficult financially to make this accommodation.

Considerations

There are some considerations in providing dental treatment for the SHCN patient. We only will use general anesthesia once per year due to the medical risks involved. Therefore, any dental treatment needed has to be performed in one visit. Many treatments such as multiple root canals are not possible due to time limitations. Consideration must be given for things like: If teeth are removed, and if replacement is desired, are removable appliance tolerable to the patient? If doing restorative treatment, can it be maintained by the patients or guardians if the patient is not able to care for their own oral hygiene? If follow-up appointments are necessary for the desired treatment, will the patient tolerate additional appointments.

A decision needs to be made as to what treatment needs to be performed and if any teeth that are badly decayed or so periodontally involved that they cannot be saved. A long discussion needs to be made ahead of the surgery as to what are the goals and desires of the guardians or, the patients themselves as some of the special needs patient are their own guardian. It is possible to have some discussions with the guardians during the treatment, but at that point, there is limited time to make decisions.

The Gorilla in the Room – Finances

Treating the majority of SHCN patients takes much more time. There are many challenges in regards to the delivery of dental treatment that require much more time than providing treatment for a person without disabilities. Some of the challenges are uncontrolled movements, spasticity, retained reflexes (such as position, noise and stress), weakness and rigidity. Many of the patients with sensory issues, especially Autistic patients depending on where they are on the spectrum, require multiple desensitization visits to our office of which there is no reimbursement. Unless you are from an institution of learning where the reimbursement is not as critical, a dentist in private practice that is providing dental treatment, is doing so out of a sense of mission. It is not done for profit. There is no business model to justify the extra time and expense it takes to properly provide dental treatment to the SHCN population.

For an example, I will use these pictures to demonstrate the low reimbursement. Show in these slides is severe calculus build up on a SHCN adult in hospital setting. It is not uncommon to provide dental treatment to SHCN adults that are on a feeding tube. Many on feeding tubes build up the calculus fast, but they seldom have cavities since their nutrition does not enter the mouth. On a case such as this, we remove the calculus, take x-rays to check for decay and do a thorough exam.

The next slide shows the reimbursement for performing the above procedures and the amount of money that my office collects for taking a half day out of my office, taking all the dental equipment to the hospital, paying two assistants time and a half and preparing all of the pre-operative and post operative paper work.

Medicaid reimburses about 1/3 to 1/2 of the normal fee and they have rules in place that are not practical for treating most special needs patients especially those that require hospitalization. If I may go back to a statement that I made earlier in my presentation, I only accept Medicaid for those patients within my community. On many, again, especially hospital cases, I do not even make enough to pay the staff that I bring to the hospital. I feel that the SHNC patients in my community are my responsibility so I do accept their Medicaid, but I cannot afford to provide this service for those outside my community unless they are children under the age of 21 in which case I will accept their Medicaid.

Why I Got Involved

If there is no financial incentive, why am I willing to care for these people? I, as many in this room, have some close connection to a special needs person whether it be a family member or close friend. I had a cousin my age that passed away at a young age. Upon graduating from dental school, I made a commitment to do my best to serve those that have special needs.

I live in a small community such as I live, these people, both special needs and the disadvantaged children, are a part of who I am. I run into either the special needs patients or their guardians on a regular basis within in the community. The Medicaid children are my children's, now my grandchildren's' best friends, I sit by them in church and see their parents in the grocery store.

In short, I feel that serving those children from financially disadvantage families and the special needs population is a part of my social and professional responsibility.

Summation

In summation, some form of sedation is needed in dentistry to provide care for certain populations. There are many that would not be able to receive dental care without sedation or general anesthesia in a hospital setting. Those most in need of sedation dentistry are children with extensive dental decay and persons of special health care needs. Adult patients of the SHCN population have the greatest of all to find access to dental care. This is due primarily to the lack of providers willing to see these patients and the lack of funding. For this population, it is a critical problem.

I do not have all of the answers on how to resolve this challenge, but an increase in funding for those willing to treat this population would maintain the participation of those that already serve the adult SHCN patients. An increase in reimbursement might also make it more attractive to entice other dentists to participate. A directory of those that are willing to provide treatment for this population and what types of sedation that the dentists provide would be beneficial as well.

Thank you for your time and consideration. I commend you for addressing this critical shortage of dental care for those persons with special health care needs.

Respectfully submitted,

Nick Rogers D.D.S.

https://www.rogersdentistry.com/