

BROKEN SMILES

RESTORING ACCESS TO ORAL HEALTH
CARE IN CHICAGO AND COOK COUNTY



CHICAGO DENTAL SOCIETY
The respected leader in scientific dental meetingsSM

Executive Summary

The state of access to dental care locally – the ability of a person in need of dental care to seek out and obtain affordable treatment – is bleak and eroding quickly. Difficult economic times have left more patients out of work and uninsured for private care, while at the same time cuts in government spending have closed several of the most accessible affordable care clinics. In essence, there are fewer options for an increasing number of dental patients.

Considering just one of many local providers, activity at the Cook County Department of Public Health illustrates the effect: the Department served nearly 11,900 dental patients in 2000, but fewer than 5,000 in 2009. Access to dental care was further eroded in 2012, when a \$1.6 billion cut in Illinois’s Medicaid program restricted adult dental benefits to exclusively emergency tooth extractions.

Indeed, recent surveys by the Chicago Dental Society found that:

- One out of every five Chicagoland residents surveyed in 2009 (22 percent) say someone in their family has dental needs now but is putting off treatment because they can’t afford it.
- More than half of Chicagoland residents surveyed in 2011 have delayed dental treatment because of financial reasons in the last year.
- Nearly 70 percent of Chicagoland dentists surveyed in 2011 say their patients are delaying needed dental treatment because of the economy.



However, Illinois's 2010 State Health Improvement Plan (SHIP) listed dental health as one of 14 public health priorities. It puts the onus on the public health system to provide "affordable cost and equitable access to oral health care." As then-Surgeon General David Satcher reported in his 2000 report on Oral Health in America, "Oral health is integral to general health." More than 90 percent of systemic diseases have oral symptoms, and a key part of reducing our nation's long-term health care costs will be to engage in more preventative oral health care and oral health education today.

In pursuit of its mission to improve oral health for all, the Chicago Dental Society has produced this white paper to examine the availability of dental care to underserved populations in Chicago and Cook County over a five year period. Having conducted this close study of the so-called "dental safety net," it has several recommendations for action from various stakeholders, as detailed in the following pages.

Among them:

- Restore Medicaid funding for preventive care, and increase reimbursement to the dentists and clinics that provide such care to ensure their doors stay open. (page 20)
- Increase oral health awareness among patients through both public health campaigns and referral networks with other health care providers, including family physicians, pediatricians and obstetricians. (page 21)
- Incentivize dentists to work with these underserved patients, and increase the workforce of hygienists and chairside assistants who work beside them. (page 21)
- Improve the collection of oral health care data that can be used to convince legislators and other grantmakers that access to oral health care must be improved. (page 22)
- Improve advocacy at the city and county levels, including public-private partnerships with mutual accountability for work toward common goals. (page 22)



Introduction

“Access to dental care in the city of Chicago is bleak because so many clinics have closed in the last five years — and the ones that are open to provide affordable care have waiting lists months long.”

MICHAEL SANTUCCI, DDS

*2012 chair of CDS’
Access to Care Committee*

Although the Great Recession officially ended in June 2009, its aftershocks persist. Not only in Americans’ workplaces, wallets and homes — but also in their mouths.

“With the hard economic times we are experiencing today, it is becoming harder and harder for people to pay for adequate dental care,” says Richard Perry, DDS, 2013 chair of CDS’ Access to Care committee.

Under the weight of economic uncertainty, the number of unserved and underserved dental patients in the United States is growing. In fact, it’s estimated that 130 million U.S. adults and children — approximately 42 percent of the U.S. population — lack dental insurance.¹ What’s more, 50 percent of uninsured and 30 percent of insured Americans have skipped necessary dental care visits due to financial burdens.²

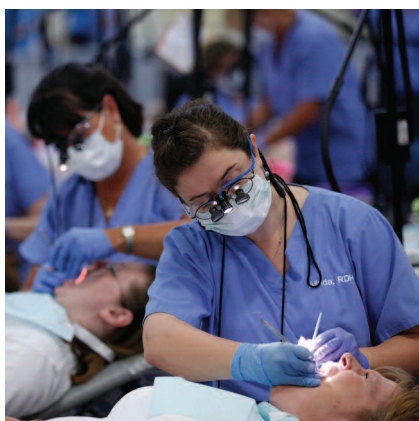
Because the Institute of Medicine says “the connections between oral health and overall health and well-being have been long established,”³ the result is an access-to-care epidemic that promises to have long-term consequences — physical, social and economic — for individuals, families and communities.

Like many other metropolitan areas across the United States, Chicagoland is faced with declining revenues and increasing costs. And with state support dwindling — in 2012, Illinois Auditor General William Holland reported that the state’s budget deficit for FY2011 was \$43.8 billion, the worst in the nation⁴ — both the city and county have had to make significant cuts to public services in order to bridge their respective budget gaps. In Cook County, those cuts have included 50 percent of public dental clinics in the last five years. In Chicago, it’s 100 percent.

“Access to dental care in the city of Chicago is bleak because so many clinics have closed in the last five years — and the ones that are open to provide affordable care have waiting lists months long,” says Michael Santucci, DDS, 2012 chair of CDS’ Access to Care Committee.

Already weak, the dental safety net in Chicago and Cook County is now threadbare, at best.

Chicago's Safety Net: Unraveled



Under Public Act 93-0975, Illinois is required to produce a State Health Improvement Plan (SHIP) every four years in order to set priorities for achieving “optimal physical, mental and social well-being for all people in Illinois through a high-functioning public health system.”⁵ The state’s most recent SHIP, published in 2010, includes oral health as one of 14 public health system priorities for the Illinois Department of Public Health (IDPH). In it, the SHIP Planning Team acknowledges that “low-income, minority and rural communities have limited access to oral health services,” that “the public health system must ensure affordable cost and equitable access to oral health care,” and that “access issues include both limited sources of care and lack of oral health coverage for services.”⁶

With these acknowledgements in mind, the 2010 SHIP lists as one of Illinois’ top public health concerns “identify[ing] and address[ing] oral health needs of communities and gaps in sources of care.”

CDS shares the state’s concern. Any discussion of access to care in Chicago and Cook County must therefore begin with an analysis of the local “safety net.”

What is the safety net?

In its 2011 report, *Advancing Oral Health in America*,³ the Institute of Medicine says the current oral health care system is composed of two basic parts: the private delivery system and the safety net, the latter of which consists of a fragmented network of providers that includes Federally Qualified Health Centers* (FQHCs), non-FQHC community health centers, dental schools, school-based clinics, state and local health departments, and community hospitals, among others.

“Some segments of the American population, namely socioeconomically disadvantaged groups,** have difficulty accessing the private dental system due to geographic, financial or other access barriers and must rely on the dental safety net (if they are seeking care),” the report explains. “While the term safety net may give the impression of an organized group of providers, the dental safety net comprises a group of unrelated entities that both individually and collectively have very limited capacity.”

* In this document, the term “Federally Qualified Health Center” will be used only to designate federally funded facilities participating in the Consolidated Health Centers program run by the U.S. Bureau of Primary Health Care (BPHC). Other facilities that do not receive section 330 funds — such as FQHC look-alikes and centers that receive only local and state funds — are not included in this definition.

**Notably, socioeconomically disadvantaged groups include racial and ethnic minorities, which make up a majority of Chicago’s population. According to the U.S. Census Bureau, the city’s population in 2010 was 31.7 percent non-Hispanic white, 32.9 percent non-Hispanic black, 28.9 percent Hispanic and 5.5 percent Asian.³³

“We’ve seen, and we’re going to continue to see, a decrease in the number of public clinics that deliver dental services.”

MILLY GOLDSTEIN
2013 chair of the CDS Foundation

Nationwide, the Institute of Medicine estimates that the current capacity of the dental safety net is 7 to 8 million people. With improved efficiency, it argues, that number could be raised to as many as 10.5 million. “However,” it stresses, “the safety net as it exists simply does not have the capacity to serve all of the people in need of care, which is estimated to be as high as 80 to 100 million individuals.”

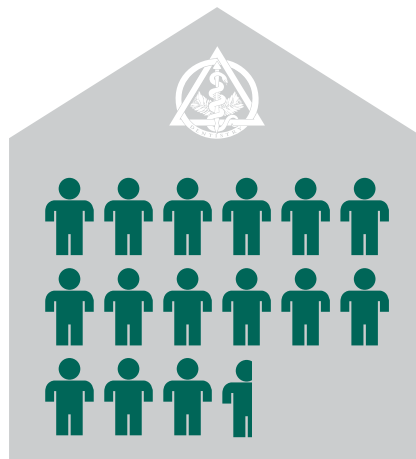
The safety net is shrinking

The dental safety net in Chicago and Cook County is equally undersized. And it’s getting smaller.

“We’ve seen, and we’re going to continue to see, a decrease in the number of public clinics that deliver dental services,” says Milly Goldstein, 2013 chair of the CDS Foundation.

As a public service, CDS compiled a list of safety net dental clinics in Cook, Lake and DuPage counties in 2006. That list included 44 clinics of various types, 24 of which were located in the city of Chicago. Five years later, in 2011, just 32 of those clinics — 18 of them in Chicago — were still open, and several lacked a dentist.

There is just **one** dental clinic in Cook County for every **15,700** uninsured children.



More than **1.5 million** Cook County residents were **registered for government health care** (i.e. Medicaid) in 2011, which is **equal to roughly half of the state’s Public Aid population.**

1.5M
COOK COUNTY
RESIDENTS ON
GOVERNMENT
HEALTH CARE



Although longitudinal data are not available, the Chicago Community Oral Health Forum (CCOHF) conducted a more comprehensive analysis of the Chicago metro area’s dental clinic supply in 2012. It found 11 school-based health centers; 53 FQHCs, FQHC look-alikes and other nonprofit clinics; eight hospital dental clinics; four educational institute dental clinics; eight public health clinics with a dental component; three military dental clinics; three mobile dental programs; and three correctional facilities with a dental component.⁴⁵

At the county level:

- More than 1.5 million Cook County residents were registered for government health care (i.e., Medicaid) in 2011,²⁷ which is equal to roughly half of the state’s public aid population. Another 115,000 low-income people will be eligible for Medicaid enrollment in 2013 thanks to a federal waiver obtained in 2012, allowing Cook County to “early enroll” individuals who are not currently eligible for Medicaid, but who will be eligible in 2014 under the Patient Protection and Affordable Care Act.⁴¹
- There is just one dental clinic in Cook County for every 15,700 uninsured children.⁷

“Dentistry was not a priority for those who made budgetary decisions for Chicago and Cook County. They put money elsewhere and closed the clinics which served as a safety net for many people when it came to obtaining dental care.”

RICHARD PERRY, DDS
2013 chair of CDS’
Access to Care Committee

■ The Cook County Department of Public Health served close to 11,900 dental patients in 2000; in 2009, it treated fewer than 5,000.⁷

Access to dental care was further eroded in 2012 when Illinois’ \$15 billion Medicaid budget was cut by \$1.6 billion, restricting adult dental coverage to emergency tooth extractions exclusively.⁴²

“There’s a significant portion of adults who don’t have dental insurance in Cook County,” says Amanda Ciatti, programs manager at Oral Health America, a Chicago-based, national nonprofit that’s dedicated to connecting communities to resources to improve the oral health of all Americans, particularly those who are most vulnerable. “Those people have [limited] options: Either they ... find a way to pay for it out of pocket at a clinic that has a sliding-scale fee structure, if they have any money at all, or they find a free dental clinic — the safety net below the safety net — in which case they have to rely completely on the benevolence of volunteers in the community who donate their services. Slots at those clinics are very limited and waiting lists are very long, so what happens is you end up in so much pain that you go to the emergency room where you’re given an antibiotic and sent on your way. Or, you simply have to do without. That’s what dental care looks like today for adults in Cook County.”



The Cook County Department of Public Health served close to **11,900 dental patients** in **2000**. In **2009** it treated fewer than **5,000**.

The safety net: 2006 – 2011

An examination of the dental safety net in Chicago and Cook County between 2006 and 2011 raises several points of concern:

■ **Local public health agencies:** In 2006, just eight of the 24 community health clinics run by the Cook County Department of Public Health offered dental care. In 2007, the county closed half of those clinics — in Markham, Robbins, Skokie and South Holland — leaving only four surviving dental clinics: in Ford Heights, Maywood, Bridgeview and Rolling Meadows.⁸

“Dentistry was not a priority for those who made budgetary decisions for Chicago and Cook County,” Dr. Perry says. “They put money elsewhere and closed the clinics which served as a safety net for many people when it came to obtaining dental care.”

Although it does accept Public Aid patients, Cook County’s main dental office at John H. Stroger Jr. Hospital has also been subject to cuts, according to Kim Morreale McAuliffe, public affairs consultant for ISDS’ Bridge to Healthy Smiles campaign, a coalition of oral health care advocates and community groups committed to bridging the access-to-care gap in Illinois. “Stroger Hospital only offers emergency care for 35 patients each day and those appointments fill up within 15 minutes,” she says. “The demand is overwhelming and the county still elected to cut the number of dental operatories by 50 percent in late 2011. More and more people are forced to rely on public dental programs at the same time government is cutting critical services that are the only option and lifeline for residents.”

Cuts by the Chicago Department of Public Health have been even more drastic, according to CCOHF, which reported in its 2011 Chicago Department of Public Health Oral Health Infrastructure Assessment and Opportunities Report that the City of Chicago “began a long-term phasing out of services” at each of its six, city-run dental clinics — in Englewood, West Town, Lower West Side, South Chicago, Uptown and Roseland communities — between 2004 and 2010.⁹

That leaves the county as Chicagoland's last safety net for public-funded dental programs. Unfortunately, Cook County's four remaining clinics — where patients must routinely wait one to three months for an appointment, according to Ms. Morreale McAuliffe — are largely inaccessible to Chicago's urban poor.

"If you look at where they are, and where there are large pockets of poverty, those clinics aren't real accessible," Ms. Ciatti says. For many city residents, that leaves emergency care as the first, last and only option. "It's about a three-week wait for emergency care. Even if you have a raging, gaping hole with an active infection in your mouth, it's going to be three to four weeks before you can be seen."

- **Dental schools:** Fifty-six of the 58 U.S. dental schools provide some degree of primary and specialty care for underserved people, according to the American Dental Association (ADA).¹⁰

Unfortunately, Illinois has just three dental schools: the University of Illinois at Chicago (UIC) College of Dentistry in Chicago; the Southern Illinois University (SIU) School of Dental Medicine in downstate Alton; and the state's first new dental school in more than 30 years, the College of Dental Medicine at Midwestern University in Downers Grove, which enrolled its first class in fall 2011. Two other dental schools — at Northwestern and Loyola universities, both in Chicago — have closed within the last 20 years, Loyola's in 1993 and Northwestern's in 2001.

Being the only remaining dental school in Cook County and Chicago, the UIC College of Dentistry in the last five years has become the de facto provider of dental care to many underserved patients in Chicago and Cook County, according to Caswell Evans, DDS, MPH, associate dean for prevention and public health sciences at the UIC College of Dentistry.

"Because there is limited dental clinic capacity in Chicago, and because of our proximity to Stroger Hospital, people who previously relied on the city and county now come to the dental school," he says. "One of the many consequences of this is that the dental school has become the largest safety net provider in the state."

Dr. Evans says patients may arrive at the dental school by 6 a.m. for one of only a handful of emergency walk-in slots. "The community sees us as a large dental clinic, which we really aren't," he continues. "A dental school is not the ideal safety net provider — but by default, we are."

- **FQHCs:** FQHCs are nonprofit health care organizations that are partially funded by federal grants. Although many offer oral health services, demand vastly exceeds supply.

"FQHC programs in [Chicago and Cook County] are quite stable," Dr. Evans says. "Many of them provide dental care, although a few don't. The issue is that they are swamped and vastly oversubscribed for the services they provide ... Most of these sites are able to get you in on an emergency basis, but their waiting lists range anywhere from a month to six months."

- **School-based health centers:** "School-based health centers are a proven, effective component of the nation's health care safety net," according to the ADA, which counts just 1,909 actual health centers connected with U.S. schools.* Although more than half of them screen children for dental problems, that number is less than 2 percent of the nation's 98,817 public schools.¹⁰

* There are 11 school-based health centers in Chicago, according to CCOHF.⁴⁵

“FQHC programs in [Chicago and Cook County] are quite stable.” The issue is that they are swamped and vastly over-subscribed for the services they provide.”

CASWELL EVANS, DDS, MPH

Associate Dean of Prevention and Public Health Sciences, University of Illinois at Chicago College of Dentistry

Despite its dental clinic shortage, Illinois outperforms many states in Medicaid reimbursements for children’s oral health. “Illinois ranks fourth or fifth [in the nation in Medicaid reimbursement rates] for preventive services for children,” says ISDS Director of Professional Services Dionne Haney.

Its adequate reimbursement rates for children’s preventive care and its All Kids health insurance program have helped Illinois achieve an increase in the number of Medicaid-eligible children accessing dental services. According to the Centers for Medicare and Medicaid Services, 42 percent of Medicaid-eligible children received a dental service in 2009 in Illinois and 40 percent preventive dental care, up from 26 and 25 percent, respectively, in 2000.¹²

Chicago has witnessed similar improvements at the local level, thanks in large part to a school-based oral health program requiring all students in kindergarten, third and sixth grade to have a dental exam completed by a licensed dentist.¹²

“The City of Chicago’s public health department has a dental outreach program in schools in partnership with Chicago Public Schools that’s expanded their ability to provide preventive services to children,” Ms. Ciatti says. “In 2004, they saw roughly 12,000 students. In the 2010 – 2011 school year, they saw 93,000. During that time there also was an increase in the number of [third-graders] with dental sealants, up from 12 percent to 34 percent.”

And yet, disparities remain. Despite its model coverage for children’s preventive care, Illinois still vastly underperforms in Medicaid reimbursements for children’s restorative care. As a result, very few Illinois dentists will provide such services to Public Aid children. And because most school-based programs similarly encompass only prevention, many children who need fillings or extractions end up in the same sparse and overcrowded clinics as their parents.

“The state has increased [Medicaid] reimbursements for cleanings and sealants, but the big worry is who’s going to take care of the children with dental caries,” says Sheila Hall, DDS, dental director at the Infant Welfare Society of Chicago. “There aren’t enough dentists who accept Public Aid and take care of pediatric patients with extensive dental caries; I’m seeing kids whose parents are driving 30 to 40 miles just to see me because I do.”

- **Private practice:** Nationwide, less than 2 percent of dentists work full-time in traditional safety net settings, according to the ADA.¹⁰ In Illinois and Cook County — where there are approximately 7,310 and 3,512 clinically practicing dentists¹³ — that amounts to less than 146 and 70 dentists, respectively. With more than 1.5 million Cook County residents registered for government health care,²⁷ it’s obvious to see: If there are only 70 dentists working full-time in the safety net in Cook County, each seeing approximately 1,500 patients per year, only 105,000 of 1.5 million patients will be seen.

Private-practice dentists must help fill the gap — and many are, often volunteering hundreds of hours and donating thousands of dollars in free care toward the oral health of underserved patients. In fact, private practice dentists provided approximately \$2.16 billion nationwide in free or discounted care to disadvantaged children and adults in 2007, the most recent year for which there is data, according to the ADA.¹⁰

“Dental practitioners are some of the most generous people around,” Ms. Goldstein says. “They [alone] can’t solve the [access-to-care] problem, but they’re trying to.”

To its credit, Illinois encourages safety-net volunteerism by awarding continuing education (CE) credit to providers who present volunteer community oral health education programs.⁴⁴ However, repairing the safety net will require a broader coalition, of which practitioners are only a part.

“The responsibility for the treatment of patients who are unable to afford dental services resides with a number of individuals,” Dr. Santucci says. “These are as follows, with the most accountability going to the first group identified: the patients who are in need of dental treatment; the City of Chicago and Cook County; the successful multimillion dollar corporations that call this city their home; the dental community that will provide the service.”

Compounding the access-to-care problem in Chicago and Cook County is Illinois’ population of Medicaid-enrolled providers, which is extremely low in direct proportion to the state’s Medicaid reimbursement rates for dental services.

“Of the 8,500 licensed and practicing dentists in Illinois, only about 2,500 dentists are actually enrolled in the Medicaid program,” Ms. Haney says.

The State Journal-Register of Springfield, Ill., reported in 2010 that only 1,000 dentists throughout Illinois are accepting new Medicaid patients. “At most, fewer than one out of every three Illinois dentists is signed up to bill [Medicaid],” it said. “And statistics indicate that as few as 10 percent of Illinois dentists are regularly billing Medicaid for service.”¹⁴

“I have always felt the obligation to treat Medicaid patients and in my 44 years of practice I have never refused a patient on Medicaid,” Dr. Perry says. “However, in today’s economy it takes far more money to operate a practice, hence making the business of dentistry far more expensive. The fees paid by Medicaid in the State of Illinois are ridiculously low and do not even cover one’s overhead expense. One may be able to treat an occasional patient, but one cannot overload their schedule or they will operate in the red and be out of business.”

New Medicaid rules⁴² restricting adult coverage to emergency extractions promise to corrode even further the pool of Medicaid-enrolled providers.



Causes



Nearly 70 percent of Chicagoland dentists surveyed in 2011 say their patients are **delaying needed dental treatment because of the economy**.

More than half of Chicagoland residents surveyed in 2011 have **delayed dental treatments because of financial reasons** in the last year.

Repairing Chicago's and Cook County's severed safety net requires first understanding the causes behind local access to care issues, which are at once economic, social and political.

Economic Factors

According to economists, the Great Recession officially ended in June 2009. The data, however, show a city, county, state and country that continue to struggle financially to the detriment of public health programs — in particular, oral health programs and clinics.

“Without a doubt, the economic state of the nation is the No. 1 contributing factor resulting in [the decline of access to dental care in Chicago and Cook County],” says CDS President David Fulton Jr., DDS.

Economic obstacles in Chicago and Cook County mirror those at the national level:

- **Revenues:** “The key issue right now is budgetary,” says CDS Past President John Gerding, DDS. “Cook County — and the whole state, which is broke — has been looking to constantly cut its budgets, and areas it’s unfamiliar with are a lot easier to cut. Dental is one of those areas.”

Consider a snapshot of the last five years, during which time reduced revenues have led to reduced public health funding, which in turn has led to cuts in the local dental safety net:

- Cook County’s total financial resources fell from \$3.08 billion in 2006 — and a five-year high of \$3.57 billion in 2010 — to \$3.03 billion in 2011.* Its general-fund tax revenues, meanwhile, fell from \$349.1 million in 2006 — and a five-year high of \$426.6 million in 2007 — to \$295.9 million in 2011.^{20**}
- Cook County reduced appropriations to the Cook County Department of Public Health from \$18.83 million in 2006 to \$17.67 million in 2011. In the same period, it reduced appropriations to Stroger Hospital from \$467.4 million to \$421.9 million.²⁰
- The City of Chicago’s local tax revenue fell from \$1.44 billion in 2006 — and a five-year high of \$1.45 billion in 2007 — to \$1.27 billion in 2011.^{21**}
- The City of Chicago reduced appropriations to the Chicago Department of Public Health from \$36.8 million in 2006 — and a five-year high of \$45.8 million in 2007 — to \$33.7 million in 2011.²¹

* Estimated

**Through November 2011

† Chicago, Joliet and Naperville, Ill.

†† Only 48 percent of workers have access to employer-offered dental plans, compared to 74 percent with access to medical plans, according to the U.S. Bureau of Labor Statistics.²⁵

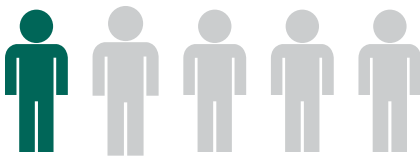
- **Unemployment:** Unemployment is partially to blame for the revenue crisis in many states, including Illinois. Nationally, the unemployment rate rose from an average of 4.6 in 2006 to 8.9 in 2011.¹⁵ In Illinois,¹⁶ Cook County¹⁷ and Chicago,¹⁸ meanwhile, unemployment in the same period rose from an average of 4.6, 4.8 and 4.8, respectively, to an average of 9.8, 10.4 and 9.8.

Because it causes increased demand for social services and reduced revenues from income taxes, high unemployment places extreme financial stress on the government coffers that fund public health programs in Chicago and Cook County.

Unemployment also increases the number of people who lack dental insurance and therefore need the dental safety net: Nationally, approximately 108 million Americans lack dental insurance — more than 2.5 times the number who lack medical insurance, according to the National Institutes of Health.¹⁹

“Unfortunately, there’s roughly 47–50 million Americans without medical health insurance, and about double those who do not have dental insurance. So, it’s about 100 million Americans who don’t have dental insurance. In Cook County, roughly 16 percent of the adult population is uninsured; if you double that, like you do nationally, that’s 32 percent of people who don’t have dental insurance,” says Ms. Ciatti, adding that the number in Chicago is even higher. The Illinois Department of Public Health, she points out, says 37.8 percent³⁷ of Chicago adults lack dental coverage. CCOHF, meanwhile, puts the number at 46 percent.²⁹

- **Costs:** Given the growing number of people who lack dental insurance, the rising cost of dental care also is a major concern, both for patients and providers.



One out of every **five Chicagoland residents** surveyed in 2009 said someone in their family has dental needs now, but is putting off treatment because they can’t afford it.

Patients

On the patient side, “financing of oral health care greatly influences where and whether individuals receive care,” according to the Institute of Medicine, which cites a 2007 study showing that in 2004, 57 percent of individuals with private dental coverage had at least one dental visit, compared to 32 percent of those with public dental coverage and 27 percent of uninsured individuals. Further, it points out, out-of-pocket payments account for 44 percent of dental expenditures, and dental services account for 22 percent of all out-of-pocket health care expenditures — second only to prescription drugs.³

High out-of-pocket costs combined with declining insurance coverage means fewer people in Chicago and Cook County are visiting the dentist.

Indeed, recent CDS surveys found that:

- One out of every five Chicagoland residents surveyed in 2009 (22 percent) say someone in their family has dental needs now but is putting off treatment because they can’t afford it.²³
- More than half of Chicagoland residents surveyed in 2011 have delayed dental treatments because of financial reasons in the last year.²⁴
- Nearly 70 percent of Chicagoland dentists surveyed in 2011 say their patients are delaying needed dental treatment because of the economy.²⁵

Providers

Given the increasingly stressed and stretched safety net in Chicago and Cook County, many argue that dental providers must be willing to bridge the gap by accepting Public Aid and Public Aid patients in greater numbers.

In fact, many are eager to do so. However, the cost of care isn't rising only for patients. It also is rising for dentists, many of whom would be unable to sustain their practice if it were opened to Public Aid patients under the current Medicaid system.

"To set up a dental office — public or private — with one chair: I don't think you could outfit it for less than [\$80,000]," Dr. Evans says. "It's unlike medicine, where you can do an awful lot with a stethoscope, reflex hammer, thermometer and prescription pad. You can't provide much direct dental care without some substantial level of instrumentation. And costs continue to rise. With that type of overhead, [sustaining a practice] is challenging."

A significant cause of access to care issues in Chicago and Cook County is not only the lack of Medicaid providers, therefore, but also the disincentives that cause it.

"Nationwide, Illinois is ranked about 48th overall in reimbursement rates for Medicaid services," Ms. Haney says.

Although Medicaid reimbursement rates in Illinois are generous for children's preventive care, they're extremely low for children's restorative care and practically nonexistent for adults thanks to a 2012 change that restricts adult dental coverage to emergency tooth extractions exclusively.⁴² In fact, Illinois reimburses Medicaid

dentists on average at a rate of 46.7 cents on the dollar.³⁸ By comparison, hospitals and pediatricians are reimbursed at rates of 77 and 84 cents, respectively.³⁹



Illinois reimburses **Medicaid dentists** on average at a rate of **46.7 cents** on the dollar. By comparison, **hospitals and pediatricians** are reimbursed at rates of **77 and 84 cents**, respectively.

"Private practices are now overburdened by the overwhelming number of patients seeking out care as a result of there being no availability through the now closed community dental clinics," Dr. Fulton says. "A private practicing dentist with a 64 percent overhead can not deliver services on a continuing basis with a reimbursement rate of 46 percent and expect to stay in business."

Few providers expect to profit on Medicaid patients. However, the need to break even on patient care is exacerbated by present-day trends: A 2012 ADA study found that between 2005 and 2009 — the most recent year for which there is data — dentists' average net income fell 11.5 percent thanks to a 2.7 percent decline per year in the number of people who see a dentist annually.²⁶

Reimbursements aren't the only issue. Equally vexing is bureaucracy, according to the Institute of Medicine, which says, "Increased reimbursement is necessary but not sufficient to increase provider participation. An increase in participation often requires additional efforts such as decreasing the administrative burdens of participation."³

Although it's widely agreed that Medicaid is the largest provider-side hindrance to access to care in Illinois, another piece of the cost puzzle is the price of dental education.

According to the American Dental Education Association (ADEA):

- 90.6 percent of graduates leave school with student loan debt.²⁸
- The average debt for all indebted graduates was \$203,374 in 2011.⁴³
- The average debt of public and private school graduates in 2011 was \$177,795 and \$245,497, respectively.⁴³
- Nearly one out of every five dental students graduates with \$250,000 or more in student loan debt.²⁸

Locally, dental school debt is even higher, according to Darryl Pendleton, DMD, associate dean for student and diversity affairs at the UIC College of Dentistry. In the UIC College of Dentistry class of 2012, he says, average debt among indebted DDS graduates was \$248,874.

Added to the high overhead of their practices and the low Medicaid reimbursement rates for their services, dentists' education debt is a significant deterrent to their participation in the safety net, not only as Medicaid providers, but also as volunteers and full-time providers in underserved areas.

"Dental education is the most expensive form of graduate education in the United States," Dr. Evans says. "It costs more to train a dentist than it does any other graduate student ... The debt burden is substantial, so the [need] to make a profit on services provided is high."

Nearly 75 percent of American adults suffer from various forms of **gum disease** but don't know it, according to the American Dental Hygienist Association (ADHA).



Social Factors

Another major source of safety-net stress is the cultural awareness and social valuation of oral health.

Major improvements in the dental safety net will not occur until the nation places greater value on oral health," the ADA argues. "Despite a growing appreciation in many quarters that oral health is integral to overall health, it remains the poor stepchild of health care in America. This phenomenon extends

from government to the media to other health professions to the public at large. This lack of recognition of the importance of oral health is manifest in government policy, in public and private health plans, in the educational system and even in the priorities that individuals set for themselves and their families."¹⁰

Social obstacles to dental care for underserved populations manifest themselves in the following ways in Chicago and Cook County:

- **Oral health illiteracy:** Access to care in many cases is limited not only by the shortage of safety net providers, but also by patients' attitude and ignorance toward oral health.

"People in a lot of communities don't believe oral health is as serious as general health," Ms. Goldstein says.

Case in point: Nearly 75 percent of American adults suffer from various forms of gum disease but don't know it, according to the American Dental Hygienist Association (ADHA), while market research firm Harris Interactive reports that 60 percent of adults over age 35 know little, if anything, about gum disease, including the symptoms, available treatments and consequences.²² Even more adults (82 percent) are unaware of the role that infectious bacteria can play in tooth decay.³¹

Exacerbating oral health illiteracy is the fact that underserved patients typically seek dental treatment only when it's an emergency. "These aren't people who are going in every six months to get their teeth cleaned," Ms. Morreale McAuliffe says. "They're people who are in crisis. They have an abscess and they are in such excruciating pain that they go to a clinic to get their tooth pulled. They don't realize that there are a lot of other steps they could have taken before getting to that point that could have prevented it from happening, and that there were other things in most cases that could have been done to restore the tooth instead of just having it pulled."

Because they don't understand oral health, underserved patients don't understand how to be patients, either. "The [safety net] population has so many other life issues that they may not know how to prioritize dental care as part of their overall health," says CCOHF Project Director Anne Clancy, RDH, MBA. "As a result, this population isn't typically making and keeping appointments. They don't always know how to be a good dental patient."

Because they similarly lack comprehension of oral health priorities, other health care providers further perpetuate oral health illiteracy by failing to refer underserved patients for dental care. In fact, just 23 percent of patients say their primary care physician or internist asked about their oral health during their most recent appointment.³¹



23% of patients say their primary care physician or internist **asked about their oral health** during their most recent appointment.

- **The public image of dentistry:** What the general public does know about dentistry often is misguided due to recent public relations efforts by cosmetic dentistry suppliers, many of which have begun marketing directly to consumers.

"Nationally, oral health and dentistry have the challenge of not being taken seriously," Dr. Evans says. "That's somewhat exacerbated by the public marketing image of dentistry over the last years of being cosmetic. People think it's all about smiles and getting your teeth whiter, neither of which is particularly germane to seminal health issues. As a result, the public image of dentistry is now that it's very superficial and very elective, which is a disservice to all."

Americans' perception of dentistry, which may dissuade many from visiting the dentist, does not match the reality: In actuality, the American Academy of Cosmetic Dentistry (AACD) estimates total annual spending on cosmetic dentistry to be \$2.75 billion — just 2.5 percent of total annual spending on dental care.²

"[Access to care] isn't about white smiles on TV," Michael Higgins, DDS, 2011 chair of CDS' Access to Care Committee, says. "It's about basic medical care."

Political Factors

Both the economic and social causes of safety-net disparities in Chicago and Cook County have roots in political discourse.

"Governments across the country are facing challenging fiscal times, and when policymakers are looking to cut programs and generate additional revenue, dental is one of the first things to go," Ms. Morreale McAuliffe says.

- **Lack of oral health awareness, advocacy:** What puts dental programs on the chopping block is that policymakers often share in their constituents' oral health illiteracy, according to David Miller, DDS, chief of the Illinois Department of Public Health's Division of Oral Health. "Part of the access-to-care issue is the general perception of dentistry," he says. "[Legislators] don't always understand that having a healthy mouth is part of having a healthy body."

A licensed dentist and former State Representative in the Illinois General Assembly, Dr. Miller became Illinois' chief dentist in 2011 thanks to an appointment by Gov. Pat Quinn.

"The position of state dental director laid vacant for the better part of five years and was only recently filled by Dr. David Miller," Dr. Evans says. "Without a state dental director there was no meaningful state presence and advocacy for oral health."

The scenery is similar in local government. Although both Cook County and the City of Chicago previously had dental directors, neither has had one during the five-year period of this report.

"The City of Chicago's public health plan doesn't even have dental care in it," Dr. Miller says. "You've got to make the new mayor* and the new aldermen aware of that. If you can get their political support, they'll be more sensitive to [oral health] when they're cutting up the [budgetary] pie. That's where it helps to have someone like me who can be an advocate and build those relationships, which sometimes individual dentists can't."

Although the causes of dental care disparities in Chicago and Cook County are many and complex, at least one, it's clear, is a lack of intra-government oral health advocacy and awareness.

"For a number of years we haven't had a dentist involved in [city, county or state] health affairs, and that's hurt our cause," Dr. Gerding says. "Without a dentist at the table, it's very easy to make cuts [to oral health]."

- **Data scarcity:** To become fluent in oral health, policymakers need leadership. They also need information, however — and there is a palpable dearth of it, especially at the city and county levels.

"Having data available for public use and inquiry is a challenge," Dr. Evans says. "There really are no convincing databases that lay out the entire access-to-care problem. There are pieces of data here and there that you can cobble together, but the data-based evidence is really not available. Evidence of the problems of access to care can be found in the health disparities data, and the day-to-day experiences of those who are underserved."

CCOHF makes the case for more localized oral health data in its report, *The Burden of Oral Disease in Chicago*:

"In order to improve the oral health of Chicago residents, there is an urgent need to collect reliable data that will further inform the level and extent of oral disease burden ... In addition, more detailed disease information affecting different sub-groups of the population will allow us to target strategies, identify disease trends, and measure oral health improvements over time."²⁹

Adds Ms. Clancy, one of the report's authors, "What happens in southern Illinois doesn't always translate to what's happening in Chicago and other places. It's very important that we get more Chicago-specific data."



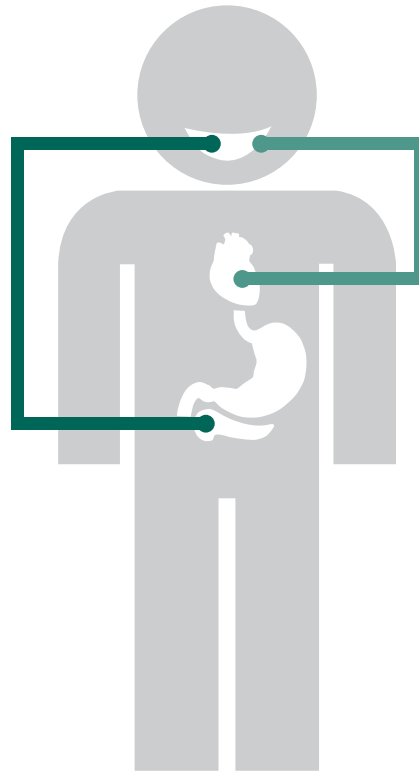
* Rahm Emanuel succeeded Richard Daley as mayor of Chicago in 2009.

Effects

Budget cuts. Unemployment. Lack of dental benefits. Oral health illiteracy. Low Medicaid reimbursement rates. Political negligence. Data scarcity. The causes of access to care issues in Chicago and Cook County are numerous. And so are the effects, which extend far beyond immediate tangibles like closed clinics and long waiting lists.

90% OF ALL SYSTEMIC DISEASES HAVE ORAL SYMPTOMS.

A **sore** or **painful jaw** could indicate an impending **heart attack** or **heart disease** and **dry mouth** could be a sign of **diabetes**. Studies have also suggested that people who have **periodontal disease** (gum disease) seem to be at a **higher risk for heart attacks**.



According to the Centers for Disease Control and Prevention:

The mouth is our primary connection to the world. It is how we take in water and nutrients to sustain life, our primary means of communication, the most visible sign of our mood, and a major part of how we appear to others. Oral health is an essential and integral component of overall health throughout life and is much more than just healthy teeth. Oral refers to the whole mouth, including the teeth, gums, hard and soft palate, linings of the mouth and throat, tongue, lips, salivary glands, chewing muscles, and upper and lower jaws. Not only does good oral health mean being free of tooth decay and gum disease, but it also means being free of chronic oral pain conditions, oral cancer, birth defects such as cleft lip and palate, and other conditions that affect the mouth and throat. Good oral health also includes the ability to carry on the most basic human functions such as chewing, swallowing, speaking, smiling, kissing, and singing.”³²

It's easy to see: Oral health is about more than teeth, and access to oral health care is about more than getting them cleaned.

Health Impacts

On May 25, 2000, Surgeon General David Satcher released Oral Health in America: A Report of the Surgeon General,³³ the 51st surgeon general's report issued since 1964. In it, he described a "silent epidemic of oral diseases [that] is affecting our most vulnerable citizens — poor children, the elderly, and many members of racial and ethnic minority groups."

Furthermore, Dr. Satcher declared: "Oral health is integral to general health."

Numerous studies have confirmed oral health as a leading health indicator. The Academy of General Dentistry, for instance, reports that more than 90 percent of all systemic diseases have oral symptoms. "A sore or painful jaw could indicate an impending heart attack or heart disease," it says, "and dry mouth could be a sign of diabetes. Studies have also suggested that people who have periodontal disease (gum disease) seem to be at a higher risk for heart attacks."³⁴

As the link between oral and systemic health is well established, the present safety net situation in Chicago and Cook County will have consequences not only for the oral health of residents, but also for their long-term health.

Community Impacts

Oral health disparities negatively impact the health of patients' bodies. They also hurt the health of their communities, however, by impacting their ability to build self-confidence, establish relationships, and succeed at school and work.

Indeed, a 2009 ADA survey found that smile outranked eyes, hair and body as a person's most attractive physical feature.³⁵ Similarly, the AACD reports that virtually all Americans (99.7 percent) believe a smile is an important social asset, while a majority (96 percent) believe an attractive smile makes a person more appealing to members of the opposite sex.³⁶

A 2008 University of Nebraska study confirmed that people who are missing front teeth are seen to be less intelligent, less desirable and less trustworthy than people who have an intact smile," Ciatti says.⁴⁰

Clearly, how a person feels about their smile affects how they feel about themselves, which in turn affects how they interact with their community and to what extent they participate in it. Oral health, therefore, is social currency, and oral health disparities perpetuate social poverty.

We all know that a cavity can cause an infection, and that an infection can cause death," Ms. Clancy says. "But if we have a community full of people who can't access oral health care, that has broader social implications, too. If you lose your teeth, or have a very un-aesthetically pleasing smile, are you going to get hired when you go out to look for a job?"

Social impacts are further evident in the classroom and in the workforce, where oral health disparities manifest themselves in pain and infections that cause diminished learning and lost productivity. In fact, the U.S. Department of Health and Human Services reports that illnesses related to oral health cause 6.1 million days of bed disability, 12.7 million days of restricted activity and 20.5 million days of missed work every year.³³ Furthermore, Ms. Ciatti says, there are 51 million school hours lost each year due to dental caries and oral disease.

* The ADA cites a 2011 position paper from the South Carolina Dental Association.



6.1M
DAYS



12.7M
DAYS



20.5M
DAYS MISSED



2.1M
DAYS LOST

The U.S. Department of Health and Human Services reports that each year illnesses related to oral health cause **6.1 million days** of bed disability, **12.7 million days** of restricted activity and **20.5 million days** of missed work. Furthermore, Ms. Ciatti says, there are **51 million school hours** lost each year due to dental caries and oral disease.

Economic Impacts

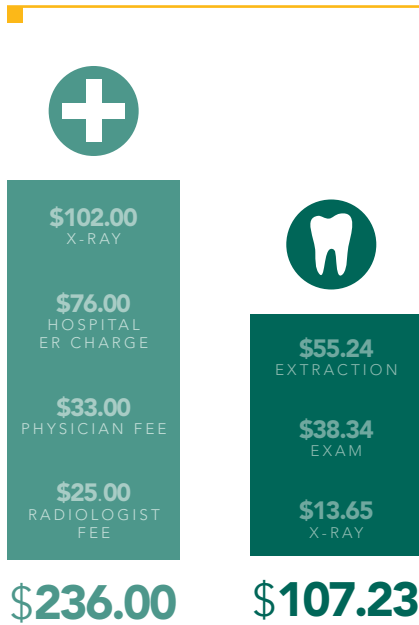
Because many of the causes of safety net stress in Chicago and Cook County are financial, it's a significant point that many of the effects — and opportunities — also are economic.

"For every dollar we spend on prevention, we save [\$8 to \$50]⁴⁶ in later treatment costs," Ms. Goldstein says.

Nowhere are the problem's economic dimensions more visible than in hospital emergency departments, according to the ADA, which reported in 2011 that a typical emergency room visit for a patient with an abscessed tooth will cost Medicaid approximately \$236, including a \$76 hospital ER charge, a \$102 X-ray, a \$33 physician fee and a \$25 radiologist fee.^{10*} And because the patient will receive only painkillers and antibiotics, not dental treatment, the problem — and expenses — will likely recur.

In a dental office, the same treatment will cost just \$107.23, including \$38.34 for an exam, \$13.65 for an X-ray and \$55.24 for an extraction. What's more, thanks to the extraction the problem will be solved and no further treatment will be necessary.

"[Access to care] really does have a long-term impact not only in terms of workforce productivity and academic productivity, but in terms of medical costs," Ms. Ciatti says. "It costs \$43 to put one sealant on a tooth, but it costs \$123 to fill the same tooth. So, it really is an investment."



According to the ADA, in 2011 a typical emergency room visit for a patient with an abscessed tooth cost **Medicaid** approximately **\$236**. In a **dental office**, the same treatment will cost just **\$107.23**.

Recommendations

The dental safety net in Chicago and Cook County is in the midst of collapse. The causes of the collapse are many and multi-dimensional. The effects are serious and far-reaching. And yet, many of the solutions are simple — and, more importantly, achievable.

As many of its peer organizations in the dental community have pointed out, CDS believes that eliminating access to care obstacles and disparities will require a multi-pronged approach engaging a diverse group of stakeholders from the public and private sectors.

Specifically, CDS advocates for the following recommendations, which it believes will improve access to oral health care in Chicago and Cook County by involving patients, providers and policymakers — all three — in the safety-net solution:

Funding

Lack of funding for oral health programs and initiatives has always been and will continue to be a major obstacle to increasing the size and strength of the dental safety net in Chicago and Cook County. CDS acknowledges that in the present economic environment, in particular, increased funding is unlikely. And yet, it believes, financial solutions can not be overlooked or dismissed solely on the basis of their cost, as investing in the near- and long-term oral health of Chicago and Cook County residents will produce measurable returns in both public health outcomes and expenses. CDS therefore makes the following recommendations:

- Increase provider participation in government-funded oral health programs by:
 - Increasing Medicaid reimbursement rates to the 64th percentile of dentists' actual costs;
 - Restoring and expanding Medicaid reimbursement of dental care for adult patients, which was restricted to emergency extractions only on July 1, 2012, as part of the Save Medicaid Access and Resources Together (SMART) Act;
 - Expanding Medicaid coverage of children's restorative care;
 - Reducing the administrative costs and burdens of Medicaid participation by eliminating extraneous paperwork, simplifying Medicaid rules and requirements, mandating prompt reimbursements and establishing an e-filing system for Medicaid billing; and
 - Helping dentists overcome negative stereotypes about the Public Aid system and Public Aid patients by offering them education and resources on the benefits of Medicaid participation and the realities of Medicaid enrollees.

- Re-open and restore closed dental clinics in Chicago and suburban Cook County.
- Provide tax credits for establishing and operating dental practices in unserved and underserved areas.
- Hire and train a network of community dental coordinators/case managers who can arrange and coordinate dental care — as well as child care, transportation and other considerations — for indigent patients to ensure they make and keep dental appointments.
- Provide FQHCs and other clinics with state grants for the purchase of dental equipment and materials so they can expand their capacity and use their resources for patient care instead of office overhead.

Red flag: Self-treatment

The medical consequences of poor oral health care access in Chicago and Cook County aren't limited to long-term health. Near-term safety also is a concern, shows a 2010 CDS survey of 300 Chicagoland dentists, 70 percent of whom have taken care of a patient who tried to self-treat their dental problems.

"The most common home treatment among patients, dentists said, is Super Glue for broken dental work, like crowns and dentures," CDS reported in February 2011. "Using an emery board to file chipped teeth or overusing topical painkillers, like teething gels, to deaden pain were also common. Remarkably, several dentists had treated patients who attempted to give themselves a root canal using power tools."²⁵

An increase in access to care obstacles, it's worried, could lead to an increase in dangerous self-treatment and associated accidents among patients.

Education

Even without new and increased capital, the dental safety net in Chicago and Cook County can — and must — be improved with alternative and preventive efforts, not the least of which are educational in nature. Believing that an oral health system based on surgical intervention is both inefficient and ineffective, CDS makes the following recommendations in pursuit of increased oral health awareness and comprehension, which are critical to oral disease prevention:

- Create a network of "dental homes" for underserved children and adults where patients can learn good dental hygiene under the ongoing care of a dedicated dentist with whom they have developed comfort and trust.
- Initiate a culturally competent public awareness campaign that communicates the importance of oral health to indigent patients in their communities.
- Provide educational resources to dentists and their staffs that will help them reduce or eliminate barriers to clear communication with their patients.
- Establish a mutually beneficial referral network with other health care providers, including family practice physicians, pediatricians and obstetricians.

Workforce

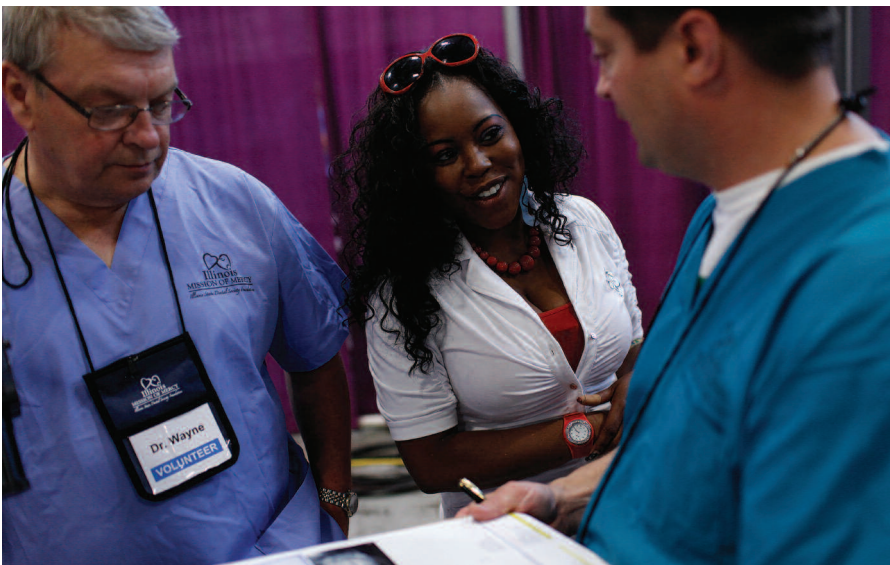
CDS does not believe that the population of dentists is a major contributor to safety-net disparities in Chicago and Cook County. Still, it must be acknowledged that much can be done to improve the efficacy of the dental workforce by redistributing and refocusing it. With that in mind, CDS makes the following recommendations that will help mobilize the local dental workforce around access to care issues:

- Incentivize more young dentists to work in safety net settings by:
 - Expanding loan repayment and forgiveness programs at the local, state and national level — including increasing the maximum grant amount that dental students can receive for loan repayment under the Illinois Dental Loan Repayment Assistance Program;
 - Offering scholarships to dental students in exchange for committing to work in unserved and underserved communities;
 - Recruiting more dental school applicants from unserved and underserved communities, with the hope they will return to those communities to begin their careers.
- Increase the supply of dental hygienists and dental assistants who can provide preventive care under the auspices of a licensed dentist.
- Train auxiliaries to take on an expanded role within dental practices by providing adjunct treatment under the supervision of a licensed dentist.

Data

Competition is fierce for the attention of grantors and policymakers. To make their voices heard over the din of countless other interests, oral health advocates must make a greater and concerted effort to quantify access to care needs, problems and solutions at the national, state and local levels. CDS therefore supports the recent efforts of the ADA, CCOHF and others to establish longitudinal oral health benchmarks that will help safety-net stakeholders attract attention and drive progress. Its specific recommendations include:

- Initiate and execute local-level research that will establish oral health benchmarks and illustrate access to care disparities in Chicago and Cook County.
- Urge safety-net providers to track and quantify their achievements in the areas of education, prevention and treatment.
- Encourage dentists to record and report the pro bono work they do outside the Medicaid system.



Advocacy

Dental providers are committed to improving access to care in Chicago and Cook County. Making meaningful progress, however, requires that their commitment be matched at the local, state and national levels by public health proponents and policymakers. A strong supporter of ISDS' Bridge to Healthy Smiles coalition, which has already made significant headway on access to care advocacy in Cook County, CDS makes the following recommendations for improving and expanding political support for oral health:


- Activate government-level leadership on oral health issues by appointing a dental director in Chicago.
- Encourage more cooperation and collaboration between safety net advocates via diverse coalitions inside and outside the dental industry.
- Establish public-private partnerships that facilitate shared goal-setting and mutual accountability.
- Help local governments access underutilized state and national resources with which to support safety net programs and initiatives.



In Conclusion

The five-year period from 2006 until 2011 saw a nation struggling to cope with recession. In Chicago and Cook County, the result was not only economic decline, but also oral disaster as demand for dental safety net services increased and supply decreased.

Nationally, the next five years will be dedicated to economic recovery. It is CDS' hope that in Chicago and Cook County, the focus will similarly be on oral health recovery. Working together toward a common goal — oral health for all — safety net providers, oral health advocates, private practice dentists and public policymakers can improve both access to and utilization of care, thereby eliminating dental inequities and establishing Chicagoland as a national model for oral health achievement.



Access-to-Care-Achievements

Recent years have been marred by an increase in oral health disparities in Chicago and Cook County. During that time, however, oral health advocates have also made significant progress toward increasing access to care. Following are a few of their most significant accomplishments:

2008: CDSF Launched

In 2008, CDS granted \$1.7 million to foundations, clinics, students and a local college to support efforts to improve dental health for all Illinois residents. A majority of the funding — \$1.5 million — went toward the establishment of the Chicago Dental Society Foundation (CDSF), which is charged with providing a stable source of income to dental education programs and dental clinics through private and corporate fundraising.

2008: Bridge to Healthy Smiles Launched

Also in 2008, the Illinois State Dental Society (ISDS) founded its Bridge to Healthy Smiles campaign, led by a diverse coalition of oral health care advocates and community groups committed to bridging the access to care gap for dental coverage in Illinois. The coalition secured several legislative victories that will improve access to care by funding dental clinics and incentivizing Medicaid providers.

2009: Dental Clinic Funding Secured

In 2009, the Bridge to Healthy Smiles coalition helped secure passage of Public Act 96-0067, which created a dental clinic grant program and procedures for communities to apply for funding of public infrastructure grants to improve access to dental care for low-income residents. Also passed was Public Act 96-37, which designated \$2 million to fund the construction of dental clinics, and Public Act 96-0926, which allows dentists who are not enrolled in Medicaid to volunteer at nonprofit clinics, including FQHCs and public health clinics, and for the sites to bill for eligible Medicaid services provided by volunteer dentists.

2010: Illinois Mission of Mercy

In June 2010, the ISDS Foundation held its first Illinois Mission of Mercy (MOM) event in Bloomington, Ill. The biggest first-time MOM held since they began in 2000, the two-day event provided more than \$1 million in free dental care to 1,953 patients.

2011: Dental Home Initiative Passed

The Illinois General Assembly passed Public Act 097-0283 in August 2011. Under the law — a key initiative of the Bridge to Healthy Smiles coalition — the Illinois Department of Health Care and Family Services and the dental community will develop and promote dental homes for children covered under CHIP, All Kids and Medicaid programs.

2011: First Local Oral Health Study Published

In 2011, the Chicago Community Oral Health Forum (CCOHF) published The Burden of Oral Disease in Chicago, the first-ever report on the burden of oral disease in Chicago.

2011: Dental Clinic Funding Secured

Cook County Board President Toni Preckwinkle approved a \$1 million earmark in the 2011 Cook County Health and Hospital System budget for outpatient dental care. In November 2011, she announced another \$1 million earmark for the 2012 budget, as well as an additional \$1 million allocation for the Access to Care organization, which facilitates primary care for residents of suburban Cook County at reduced rates. The additional allocation brought the county's total funding for the Access to Care organization to \$3 million in 2011.

2012: Illinois Mission of Mercy

In June 2012, the ISDS Foundation hosted its second Illinois MOM event in Grayslake, Ill. During the event, more than 1,100 volunteers delivered over \$1.13 million in dental, vision and medical care to more than 2,000 patients.

2012: Chicago Oral Health Plan Unveiled

In September 2012, CCOHF unveiled its Chicago Area Oral Health Plan. A product of CCOHF's first Oral Health Summit, it is designed to catalyze systems-level changes that improve access to dental care for Chicagoland residents.

2012: CDSF Launches Clinic Tool

In September 2012, the CDS Foundation introduced an online tool for finding dental clinics in Cook, DuPage and Lake Counties. It includes information on more than 100 Chicagoland clinics and dental services.

2012: Medicaid Early Enrollment Waiver

In 2013, 115,000 people will be newly eligible for Medicaid thanks to a federal waiver obtained in October 2012, allowing Cook County to "early enroll" individuals who are not currently eligible for Medicaid, but who will be eligible in 2014 under the Patient Protection and Affordable Care Act.⁴¹



References

- ¹ National Association of Dental Plans, "Dental benefits improve access to dental care," 2009, http://www.nadp.org/Libraries/HCR_Documents/nadphcr-dentalbenefitsimproveaccessto-care-3-28-09.sflb.ashx.
- ² DentalPlans.com, "Fast Facts & Figures," <http://www.dentalplans.com/press-room/dental-facts-figures.asp>.
- ³ Institute of Medicine, "Advancing Oral Health in America," 2011, http://www.nap.edu/openbook.php?record_id=13086.
- ⁴ Sunshine Review, "Illinois State Budget," http://sunshinereview.org/index.php/Illinois_state_budget.
- ⁵ Illinois General Assembly, "Public Act 093-0975," <http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=093-0975&GA=093>.
- ⁶ Illinois Department of Public Health, "Illinois State Health Improvement Plan 2010," http://www.idph.state.il.us/ship/09-10_Plan/SHIP_Final_2010.pdf.
- ⁷ Illinois State Dental Society, Bridge to Healthy Smiles, "Bridge to Healthy Smiles: The Need," <http://www.bridgetohealthysmiles.com/need.php>.
- ⁸ The Chicago Tribune, "County to assess state of oral care," http://articles.chicagotribune.com/2010-11-15/news/ct-x-c-oral-healthcare--20101113_1_dental-clinics-oral-health-dental-services.
- ⁹ Chicago Community Oral Health Forum, "Chicago Department of Public Health Oral Health Infrastructure Assessment and Opportunities Report," 2011.
- ¹⁰ American Dental Association, "Breaking Down Barriers to Oral Health for All Americans: Repairing the Tattered Safety Net," 2011, <http://www.ada.org/sections/advocacy/pdfs/breaking-down-barriers.pdf>.
- ¹¹ Centers for Medicare & Medicaid Services, "Medicaid Dental Coverage: State Reports," 2008, <https://www.cms.gov/MedicaidDentalCoverage/Downloads/dentalfinal.zip>.
- ¹² Chicago Public Schools, "Dental examinations and oral health program," http://www.cps.edu/Programs/Wellness_and_transportation/School_health_services/Pages/SchoolBasedOralHealth.aspx.
- ¹³ Illinois Department of Public Health, "Illinois Dental Workforce Census Report," 2006, http://www.idph.state.il.us/healthwellness/oralhlth/Dental_Workforce_Census2006_09.pdf.
- ¹⁴ The State Journal-Register, "State can't afford to improve dental service for poor, official says," <http://www.sj-r.com/top-stories/x1328938749/State-cant-afford-to-improve-dental-service-for-poor-official-says>.

- ¹⁵U.S. Bureau of Labor Statistics, "Labor Force Statistics from the Current Population Survey," <http://data.bls.gov/timeseries/LNS14000000>.
- ¹⁶U.S. Bureau of Labor Statistics, "Local Area Unemployment Statistics: Illinois," http://data.bls.gov/timeseries/LASST17000004?data_tool=XGtable.
- ¹⁷Illinois Department of Employment Security, "Local Area Unemployment Statistics," <http://www.ides.illinois.gov/page.aspx?item=908>.
- ¹⁸U.S. Bureau of Labor Statistics, "Local Area Unemployment Statistics: Chicago-Joliet-Naperville, IL Metropolitan Division," http://data.bls.gov/timeseries/LAUDV17169703?data_tool=XGtable.
- ¹⁹National Institutes of Health, "Oral Health in America: A Report of the Surgeon General," 2000, <http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/sgr>.
- ²⁰Cook County Bureau of Finance, "Annual Budget," 2006 – 2011, http://www.cookcounty-gov.com/portal/server.pt/community/finance%2C_bureau_of/312/annual_budget/443.
- ²¹City of Chicago Office of Budget and Management, "City Budget," 2006 – 2011, http://www.cityofchicago.org/content/city/en/depts/obm/provdrs/city_budg.html.
- ²²DentalPlans.com, "Dental Care Facts," <http://www.dentalplans.com/press-room/dental-care-facts.asp>.
- ²³Chicago Dental Society, "The State of the Tooth: Findings from a dental health survey of 300+ Chicagoans," 2009, <http://www.cds.org/Page2Column.aspx?PageID=34&id=399&terms=clinic>.
- ²⁴Chicago Dental Society, "Chicagoans Discuss Dental Habits, Teeth Trends and More," 2011, http://www.cds.org/News/Press_releases/Press_Release_Listing/2011/Chicagoans_Discuss_Dental_Habits,_Teeth_Trends_and_More.aspx.
- ²⁵Chicago Dental Society, "Surprising Number of Patients Try Super Glue Before Visiting Dentist," 2011, <http://www.pitchengine.com/chicagodentalsociety/surprisingnumberofpatientstrysupergluebeforevisitingdentist>.
- ²⁶Medscape Medical News, "Dentists' Incomes Dropping, Says ADA Survey," 2012, <http://www.medscape.com/viewarticle/763550>.
- ²⁷Illinois Health care and Family Services, "Number of Persons Enrolled in Cook County," <http://www2.illinois.gov/hfs/agency/Program%20Enrollment/Pages/cook.aspx>.
- ²⁸American Dental Education Association, "2011 ADEA Official Guide to Dental Schools," http://www.adea.org/publications/Documents/OG_2011/Chapter%204.pdf.
- ²⁹Chicago Community Oral Health Forum, "The Burden of Oral Disease in Chicago," 2011, http://www.heartlandalliance.org/oralhealth/tools/the_burden_of_oral_disease_in_chicago.pdf.
- ³⁰U.S. Census Bureau, "Chicago QuickFacts From the U.S. Census Bureau," <http://quickfacts.census.gov/qfd/states/17/1714000.html>.
- ³¹Philips Sonicare, "New Survey Shows Americans Value Oral Health but Knowledge Gap Remains," http://www.harrisinteractive.com/vault/Client_News_Phillips_2008_05.pdf.
- ³²Centers for Disease Control and Prevention, "The Burden of Oral Disease: Tool for Creating State Documents," 2005, <http://www.cdc.gov/oralhealth/library/burdenbook/chapter1.htm>.
- ³³U.S. Department of Health and Human Services, "Oral Health in America: A Report of the Surgeon General," 2000, <http://www.surgeongeneral.gov/library/oralhealth>.

- ³⁴Academy of General Dentistry, "Is There a Connection Between Heart Disease and Gum Disease?" 2009, <http://www.agd.org/about/newsmedia/pressreleases/Default.asp?PubID=45&IssID=953&ArtID=5414>.
- ³⁵American Dental Association, "Survey Finds Smile Is 'Most Attractive' Physical Feature," 2009, <http://www.ada.org/3283.aspx>.
- ³⁶American Academy of Cosmetic Dentistry, "Whitening Survey," 2011, http://www.aacd.com/proxy.php?filename=files/Footer%20Nav/Whitening%20Survey_Apr11.pdf.
- ³⁷Illinois Department of Public Health, "Illinois Behavioral Risk Factor Surveillance Survey," 2007–2009, http://app.idph.state.il.us/brfss/countydata.asp?selTopicCounty=oralhth&areaCounty=Chicago_10.1&show=freq&yrCounty=4&form=county&yr=&area=&selTopic=].
- ³⁸The Pew Center on the States, "The Cost of Delay," 2010, http://www.pewcenteronthesates.org/uploadedFiles/Cost_of_Delay_web.pdf.
- ³⁹The American Academy of Pediatrics, "Medicaid Facts: Illinois," June 2011, <http://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/access-to-care/MedicaidFactSheets/Illinois.pdf>.
- ⁴⁰M. Willis, C. Esqueda, and R. Schact. "Social Perceptions of Individuals Missing Upper Front Teeth." <http://www.ncbi.nlm.nih.gov/pubmed/18556899>.
- ⁴¹Cook County Health and Hospitals System, "Cook County Captures 1115 Waiver," 2012, <http://www.cookcountyhhs.org/announcements/john-h-stroger-jr/county-captures-1115-waiver>.
- ⁴²The New York Times, "Sharp Cuts for Dental Coverage for Adults on Medicaid," 2012, <http://www.nytimes.com/2012/08/29/health/policy/hard-to-grin-while-bearing-cuts-in-medic-aid-dental-coverage.html>.
- ⁴³American Dental Education Association, "Survey of Dental School Seniors, 2011 Graduating Class," <http://www.adea.org/publications/tde/Documents/See%20all%20Predoctoral%20Student%20Debt%20Tuition%20Graphs.pdf>.
- ⁴⁴Illinois Department of Financial and Professional Regulation, Joint Committee on Administrative Rules, "Administrative Code: Section 1220," <http://ilga.gov/commission/jcar/admincode/068/06801220D04400R.html>.
- ⁴⁵Chicago Community Oral Health Forum, "Chicago Area Oral Health Plan," 2012, <http://www.heartlandalliance.org/oralhealth/chicagoland-oral-health-plan-final-9-2012.pdf>.
- ⁴⁶Cigna, "Improved Health and Lower Medical Costs: Why Good Dental Care Is Important," 2010, http://www.cigna.com/assets/docs/life-wall-library/Whygooddentalcareisimportant_whitepaper.pdf.

Acknowledgements

The Chicago Dental Society recognizes and thanks the following individuals for their contributions to the Shattered Smiles: Restoring Access to Oral Health Care in Chicago and Cook County white paper:

Amanda Ciatti
Programs Manager
Oral Health America

Anne Clancy, RDH, MBA
Project Director
Chicago Community Oral Health Forum
Heartland Health Outreach

Caswell Evans, DDS, MPH
Associate Dean of Prevention and Public Health Sciences
University of Illinois at Chicago
College of Dentistry

David Fulton Jr., DDS
2013 President
Chicago Dental Society

John Gerding, DDS
2012 President
Chicago Dental Society

Milly Goldstein
2013 Chair
Chicago Dental Society Foundation

Dionne Haney
Director of Professional Services
Illinois State Dental Society

Michael Higgins, DDS
2011 Chair
Access to Care Committee
Chicago Dental Society

Richard Perry, DDS
2013 Chair
Access to Care Committee
Chicago Dental Society

David Miller, DDS
Chief, Oral Health Division
Illinois Department of Public Health

Kim Morreale McAuliffe
Public Affairs Consultant
Bridge to Healthy Smiles

Darryl Pendleton, DMD
Associate Dean for Student and Diversity Affairs
University of Illinois at Chicago
College of Dentistry

Michael Santucci, DDC
2012 Chair
Access to Care Committee
Chicago Dental Society

ABOUT THE CHICAGO DENTAL SOCIETY

The Chicago Dental Society is an association for dentists in the metropolitan Chicago area; organizer of the Midwinter Meeting, the leading scientific dental meeting and tradeshow; and an advocate for improving oral health for all.

Since its founding in 1864, and incorporation in 1878, CDS' mission has been to encourage the improvement of the health of the public, to promote the art and science of dentistry and to represent the interest of the members of the profession and the public that it serves.

CDS counts more than 6,100 dentists as members.

For more information, visit the Society's website, www.cds.org.



CHICAGO DENTAL SOCIETY
The respected leader in scientific dental meetingsSM