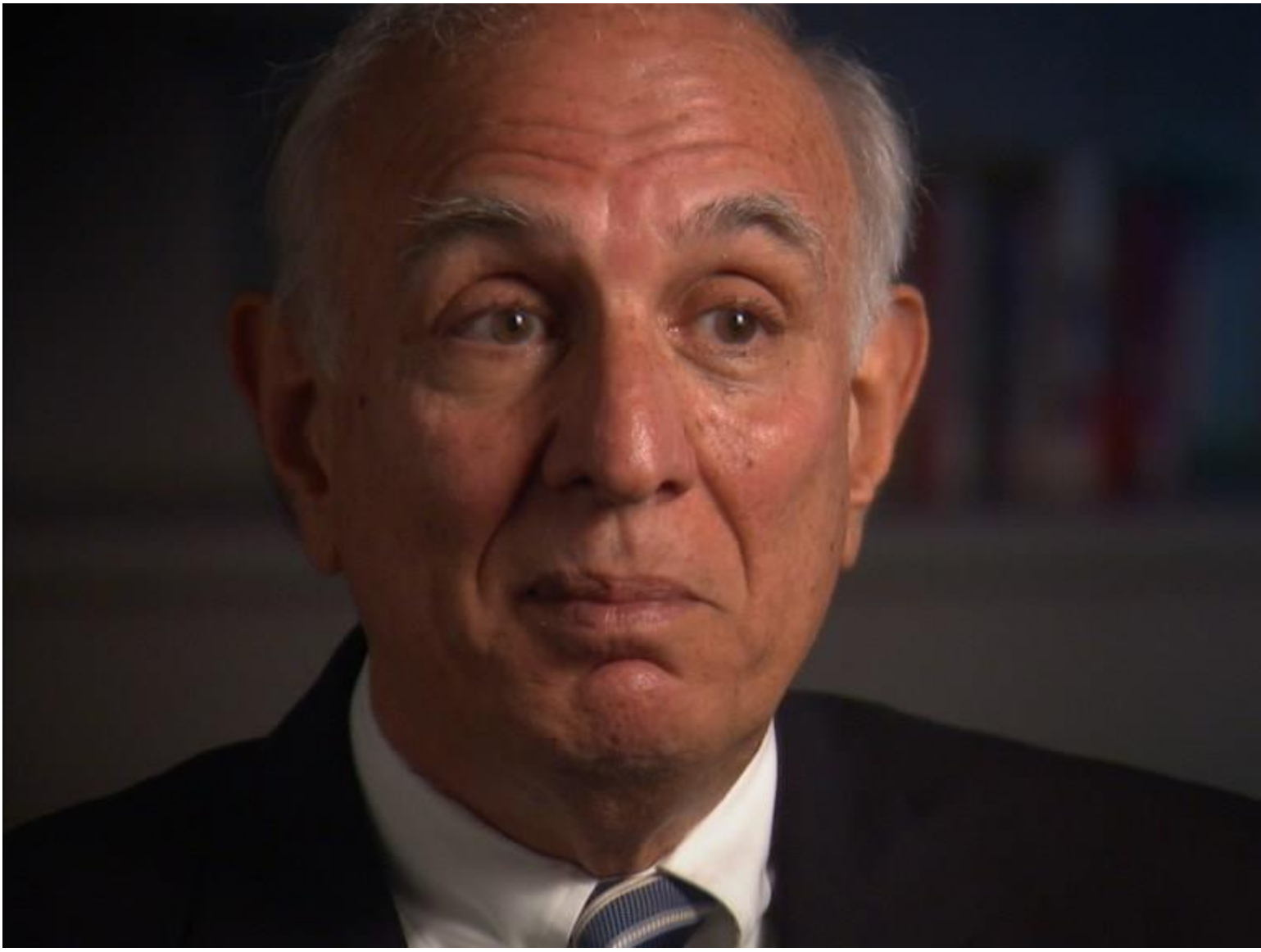
JUNE 26, 2012
/

by JASON M. BRESLOW



Frank Catalanotto, D.M.D., is the chair of the Department of Community Dentistry and Behavioral Science at the University of Florida. He tells FRONTLINE that holes in Medicaid are one reason why more than 100,000 patients wind up in Florida emergency rooms each year for dental problems. The system would benefit from more midlevel care providers, he says, although that idea has met resistance from the American Dental Association. “My argument is, OK, if you don’t want to or can’t take care of those patients, just get out of the way and let us who want to propose solutions take care of them,” Catalanotto said. This is the edited transcript of an interview conducted on May 3, 2012.

Out of curiosity, how did you become so fervent about this issue?

I was a typical middle-class kid who didn’t understand that dental access problems were a serious problem in the early part of my career.

But in 1985 I moved to San Antonio … and I got to spend two weeks on a border town called San Elizario, on the border between Mexico and Texas. And I saw hardworking people with tremendous disease problems — not just oral diseases, dental diseases, but a variety of others — trying to do better. And that's what started to make me aware that there was this serious problem in this country.

I get the sense not a lot of dentists have that experience, and that might be part of the problem.

That is a serious part of the problem. Most dentists come from middle-class families or upper-middle-class families. They make a very high income. They see the patients that come to their practice, and they think everything is fine because those patients are getting care in their office. What they don't see are the 60 [million] to 100 million individuals that don't have dental insurance. Even the ones that have Medicaid can't get access because … reimbursement rates are so low.

Should we fault them for that?

In one sense, you can't really fault them for that, and in another sense, they know the problem. They have been told about the problem for years. We've got all sorts of data that would demonstrate that. I mean, very, very recently we had data in Florida that looked at emergency room visits for preventable dental conditions. In 2010, across the state of Florida, 110,000 emergency room visits for a preventable dental problem. You have to see that data and recognize that there is a problem.

You feel dentists owe the community, society in general, more?

Well, there's no doubt. A wonderful medical ethicist named Edmund Pellegrino used the term "the moral aspects of professionalism." So, yes, we owe something back to the public. That can be some philanthropic care. But you can't build a system of care on philanthropic care. What you really need is a system of organized care, a system that has appropriate reimbursement for those who can't afford it, a system that has education so patients can help prevent their own disease, and a system where dentists are rewarded for preventing disease rather than filling teeth.

It’s interesting how many state laws are pretty much hand-tailored by the dentists themselves. It’s the fox guarding the chicken coop, isn’t it?

Well, the state laws are passed by state legislatures. They are influenced by two kinds of activities, first, by the state board of dentistry, and frequently then the professional dental associations have a say in who gets on that state board of dentistry.

And then they’re influenced by the lobbying power. The Florida Dental Association is a perfect example, where they have four full-time lobbyists in Tallahassee, the state capital, and they’re influencing legislation. And those of us who are fighting for improvements and access are not well funded, we’re not well organized, and nor do we have the time to spend full-time lobbying at state capitals or here in Washington.

So dentists are spending a lot of money to maintain the status quo.

They are.

Why?

Because the status quo was good for dentists, and it’s good for those patients who can get to dental offices. I want to be very clear: The majority of folks in this country can get good dental care from their dentists. Middle-class people can afford to go to a dentist and get dental care.

The group that we are most concerned about are the group that are in poverty and the other group that are called the working poor. Those are folks who have jobs, but they don’t have good benefits. They are usually hourly workers that you see are not really good — they have no dental benefits; they live paycheck to paycheck. A dental crisis in their family is going to cost several hundred dollars. It’s going to cost time out of the workplace, and they’re an hourly wage person. Those are the group I’m concerned about.

Are poor people in this country owed dental care?

What we believe is that there are certain rights that you have in this country, and the right to health care is one of them.

Let's talk about Trinity Way.

Yes.

The story of Trinity Way is a real eye-opener, I think, for people. How common is the Trinity Way story?

We have a pediatric dentistry residency program at the University of Florida, where we have 10 residents. That program has a six-month waiting list for a child to be seen by them. That is typical of the Trinity Way problem.

Trinity's grandmother tried to find a dentist knowing that Trinity had some dental problems. Tried to find a dentist. She lives about an hour from Gainesville, where our clinics are, could not find a dentist. She finally got to our program. However, her needs were so great that the best and most efficient way, and the way kindest to her, was to put her to sleep with some general anesthesia to fix all of her teeth at one time. That is very typical in a place like Florida.

It shouldn't be typical, though, should it?

It shouldn't be typical. A parent should be able to call and get care relatively quickly for a dentist.

Trinity Way could have just as easily gone the way of Deamonte Driver.

And we believe that is occurring, and we just don't know it. We have some data that we looked at a couple of years ago that there were over 1,000 admissions to Florida hospitals by physicians for children whose dental infections had gotten so bad that they couldn't be handled on an outpatient basis by the physician.

A thousand?

A thousand across the state. That was in 2006.

That's a big number.

That's a very big number and an enormous cost, plus the potential danger to that child.

In the dental world, it's like a separate union, so to speak, right? You know, you walk into the emergency room; if it's a tooth problem, they're like, "No, no, no, we don't do that here." Should it be that way?

Well, there is a workforce issue. I mean, hospital emergency rooms are simply not equipped unless they happen to be associated with, for example, a residency program in dentistry of some type or another.

So all they're equipped to do is give some pain medication, give some antibiotics if there's an infection, and refer the patient to find a dentist on Monday morning or the next day. The problem is those patients can't find the dentist, or for some other reason they neglect to do so. They're back in the emergency room. The data is pretty clear. Those 110,000 patients, there are a number of repeat patients there.

One hundred and ten thousand. These are dental cases that present themselves to emergency rooms?

This was last year in Florida: One hundred ten thousand patients went to hospital emergency rooms for a preventable dental emergency.

Well, this has got to cost a lot.

Well, the one example in Florida, $88 million in 2010 for this. Think about what I could do with that $88 million in terms of getting preventive care.

Prevention is the key, and I hear this time and again from dentists who say, "Well, you know, if the poor people [came] in sooner and we didn't have them so late in the game where there is such huge problems" — there is a little bit of blaming the victim here: You know, poor people don't know enough to clean their teeth. What do you say to that?

"Think about what I could do with that $88 million in terms of getting preventive care."

When you are poor and your family can barely afford a toothbrush, it is hard to make a decision that I need some dental care because — I don't know, I make

decisions based on paying my rent, buying food, buying clothes for my children. Dental care seems like an optional benefit, because most of the public does not understand how important dental care is.

Does it make any sense to be treating kids like Trinity Way in a hospital, in an emergency room?

No, it doesn't. … In Florida now, we are one of 45 states where physicians are now actually reimbursed by Medicaid for providing preventive services. Do you think the state would do that if this was not cost-effective?

In the case of Trinity, when it gets that far down the road, and the care required involves general anesthesia, you know, full-up surgery — give us a sense of how much that dramatically increases the amount of care and the cost of care specifically.

So if I were able to see Trinity in my dental office to restore one or two of her teeth, I could do that in my office. The costs are the normal costs of my office; the local anesthesia; the supply is my staff.

If I have to take Trinity to the hospital, the costs involved are, first, I have to get a medical approval. She has to be evaluated by a physician. Then we have to book time in the operating room. That's an operating room nurse; that's an anesthesiologist who has to provide the general anesthesia. That's all extra costs of infection control that go on in a hospital.

I have to leave my practice, go over there with an assistant with all my supplies, take a couple of hours to do that work. We could be looking at a bill of between $5,000 and $10,000 depending on where it is done and the cost of that particular hospital.

And of course in the case of Deamonte Driver, I've seen [a] figure approaching $250,000 was the total bill before ultimately he died. Trinity could have been a Deamonte.

Trinity could have been a Deamonte Driver very easily if the grandmother had not been able to find a dentist. If she had not found us at the University of Florida and that infection had gotten "systemic" is the term that we use — an elevated

temperature, a severe infection — she could have died; she could have had major medical complications. We believe that this occurs probably more often than we would like to think.

The fact that it becomes so desperate for people is a deeply rooted problem. We were talking about education for one thing. That's not an easy thing to fix. People, first of all, I think generally would prefer to avoid going to the dentist. They have a sense that this is not a pleasant thing, you know — and don't take that personally.

I don't.

And secondly, as you say, there is this tremendous lack of education. That's a huge problem to try to solve, isn't it?

It is a huge problem to solve on the one hand, but when you look at the simplicity of the message that you need to get to parents — and I'll tell you that because we do this all the time, and this is what I teach physicians to do, and I can teach this very, very quickly. The message is very simple: Brush your children's teeth twice a day with a fluoridated toothpaste. Avoid frequent snacking. Take your child to the dentist. That's the simple message. If I can get that message to parents, we can prevent this problem.

What about the soda pops?

That's part of the frequent snacking that I was talking about — so, soda pops, sticky fruit, sticky candies, things like that where sugar that are in those products sticks to the child's teeth. But if I can brush twice a day and if I can avoid those, I can avoid this problem. Don't put your child to bed at night with a bottle if it's a very young child. Don't put Kool-Aid in a sippy cup. These are simple messages. Any parent can understand those messages.

Is it possible to make a dent, though, when you talk about all the pressures at that socioeconomic level they have as far as diet, education and everything else, it's just the lack of money to really move the needle on that?

There is data to suggest that if I can get prevention early in a Medicaid population, I can save money long-term. Another study out of … North Carolina

showed that if Medicaid children start with their dentist at age 1 as opposed to children who started at age 2, 3, 4 or 5, those children who started at age 5 had approximately three times the cost of those children who started at age 1, where we were paying for the prevention from age 1. In other words, they didn't need fillings, caps, crowns at 5 years of age. It saved money.

Where do dental therapists fit into all this as sort of midlevel care?

So a concept that has newly hit in the United States but has been used internationally for over 60 years is the midlevel provider. The common term is a dental therapist. These are individuals who around the world have approximately two years of training, and they are used in remote areas and in less remote areas and used in modern countries like New Zealand and Australia and England.

In the literature it's very clear: They can be trained to treat patients safely and effectively. They are able to reduce disease and provide appropriate care, and the long-term costs are less expensive than trying to get at that care with dentists. We now have two models of those dental therapists in the United States — in the state of Alaska and in the state of Minnesota. It's a little bit too early to look at the data, but the preliminary data coming out of Alaska is that they are safe and effective and can provide care.

These are Native American Eskimos that come from the communities. They go back to those communities; they live in those communities. So not only maybe are they taking care of filling teeth on Monday and Tuesday, but they are in the school on Wednesday doing the education. They are going into the homes and watching and educating the public.

So dental therapists work. We need more models in the United States.

Dentists generally don't like that idea.

Dentists very much don't like that idea. And I'm embarrassed to say that my colleagues are ignoring the international data that dental therapists are safe and effective and could be an appropriate solution here in the United States to reaching the underserved population.

The argument is: “I’m a trained professional; there is a reason I went to school and did all the things I did. We could be putting people in jeopardy by allowing them to be treated by somebody who doesn’t have the same training.” What do you say to that?

“I’m embarrassed to say that my colleagues are ignoring the international data that dental therapists are safe and effective and could be an appropriate solution.”

I understand that feeling. I’ve been to school for four years of college, four years of dental school and three years of graduate work. But I have to look at the literature. Dentistry says that we pride ourselves on being an evidence-based profession, that we follow the literature. If the literature supports something, we will follow that. The evidence on dental therapists [is] absolutely clear. … So I say to my dental colleagues, if you say you believe in evidence-based dentistry, you have to give this a try.

Maybe there are some other reasons?

There might be some other reasons, and I think it’s fear of losing patients to their practice, income. And right now is a particularly bad time. We are in the middle of a recession. There are dental practices that are hurting. But I think those dentists are missing the point that we have this group that are not getting any care. And if I can get care from a person with two or three years of training that is appropriate, safe and effective, that’s what I want to try to do.

Sometimes I get the sense that when you talk to dentists, they say this issue of access [is] sort of not their problem. Is it their problem? Should it be?

This is a societal problem. Dentists should not be expected to give away their services. They should not be expected in large part to do a lot of pro bono care. They should do some pro bono care. It’s part of our professional obligation, OK? The difficulty is the group that cannot afford the services in a traditional dental office. And my argument is, OK, if you don’t want to or can’t take care of those

patients, just get out of the way and let us who want to propose solutions take care of them and take care of them with better utilization of our existing workforce, the dental hygienists, and now implementation of the dental therapist model.

> “My argument is, OK, if you don’t want to or can’t take care of those patients, just get out of the way.”

A lot of dentists probably would say to you — maybe they have — “Frank, you are ruining a good thing.”

I hear that all the time. I know that I cause difficulty for the profession, but we have to speak out; we have to address this problem.

Dentists who are doing well, have a good practice blocking access to care, it’s hard to understand that.

Well, it’s hard to understand that except if you understand that the American Dental Association is first and foremost fighting for dentists, and then second fighting for access-to-care issues. That is their job. Their dues-paying members expect that. I don’t necessarily believe that is the right thing to do, but I’m still a member of the American Dental Association; I still pay my dues. But I try to fight from the inside.

The ADA is misguided?

In this issue I think the ADA is misguided. The ADA has done a bunch of wonderful things. The new emphasis on evidence-based care is I think a tremendous benefit that the ADA has provided the public and the profession, but resistance to these issues about improving access, I believe, is wrong.

And at the core, what is it? Is it worry about control, losing your business? Is it just worry and fear of change?

If you go back to the model of dentistry, the typical model of dentistry is the cottage industry, the individual dentist in their practice. When that dentist is not

there, there is no income coming into that practice. So that tells you it's loss of control. It's fear of the unknown. It is fear of the loss of income, the loss of status, the loss of the sense of professionalism.

When you go to dental meetings, are you kind of like the skunk at the picnic?

Well, I stopped going to those meetings. … I do believe the American Dental Association is slowly moving in the right direction. I do believe that the leadership is starting to get the message. So I believe I need to continue to fight from the inside.

I just met this week with the current president of the American Dental Association, the executive director, and we were talking about these issues, and he got up on the stage and talked about the profession trying to be more open to these changes.

It occurs to me that as you talk about this movement in the business, do you get the sense among dentists that they see the winds blowing in this direction and they'd better get out ahead of this or perhaps face restrictions, regulations that they would not want?

What I have been saying for 20 years is that if the profession does not fix the problem, even though it's not the profession's total problem, government will fix the problem for them. And that is what is happening. That's what happened in the Affordable Care Act. We now have mandated dental benefits for children in the Affordable Care Act. We did not try to get adult benefits. We just simply knew that the economic and political times were not right for that.

Is there a governmental solution here? Is that what it's all about? A lot of dentists would say, "Oh, gosh, the government, this is going to be a problem."

Well, if the obligation of government is to provide care and resources for those who are unemployed, for those who are poor, those who do not have access to health care, in that sense I see a government solution. Should the government necessarily interfere with middle-class and upper-middle-class patients and that doctor-patient relationship? No, I don't see any reason why they should.

On the other hand, look, schools are run by government. Everyone has access to education in this country because of that. Health care is one of those things where we need to help provide access to those who can't afford it or can't get it through the traditional approaches. That is where the appropriate but limited role of government could be.

Is it as simple as completely streamlining Medicaid across the board so that dentists, no matter where they are, would at least be able to pay the rent by seeing a decent proportion of Medicaid patients?

There are two problems with Medicaid. One is the administrative aspects. And yes, it's different in every state, and it is cumbersome, right? That has to be fixed, and there are states that are working toward that in collaboration with organized dentistry.

The fees are a different matter. The fees where you have services mandated by the federal government, who does provide some funding but then also state governments, and each state is different.

So you get a state like Florida which has not funded Medicaid very well, and we therefore have some rates that are among the lowest in the country. You have states like Alabama, which have a reasonably good fee reimbursement schedule. However, you still have issues where there's still a lot of dentists in Alabama that are providing care. We need to understand the reasons for that and try to fix that. So yes, streamlining the administrative process and fixing the fees is one way toward improving access for the Medicaid population.

If you're a dentist in Florida, there isn't much incentive to see Medicaid patients, is there?

No. Dentists in Florida, particularly a general dentist who is not equipped to treat children in volume, essentially gets a reimbursement that might cost him or her money and then actually be lower than the cost of providing that care. So no, there are not a lot of incentives in Florida.

So there aren't many dentists who see this.

Only 10 percent of Florida dentists participate in the Medicaid program.

Wow.

That's awful.

That's a lot of underserved people.

So the result is that only 25 percent of Medicaid-eligible children get any kind of dental care. And by any kind of dental care, I mean one visit a year. If you go to the really vulnerable group, the group under 6, it's less than 10 percent of those children get any kind of dental care.

You mentioned Alabama. Sarrell [Dental Center] is a model we've looked at. Is that part of the solution?

Sarrell is part of the solution. And [the] Sarrell model is really very, very simple despite all the mystique. Sarrell is managed and run by a former corporate CEO of a Fortune 500 company. He understands business principles. So they only provide care to Medicaid patients. They have been extremely successful financially because he applies hard-nosed business principles to running those clinics. And this past week they opened their 15th clinic in the state of Alabama. They provide care to well over 100,000 patients. They take no grants, no donations, only take Medicaid fees by using good business principles. That's how it works.

Much to the chagrin of dentists in Alabama.

Much to the chagrin of dentists in Alabama who actually tried to close the program. They tried to shut him down a couple of years ago. It's embarrassing the things that they did.

What do dentists there say now?

They don't say anything right now. I have not heard anything new in terms of trying to stop what he is doing. I know he would like to continue to expand the model. I think he would like to probably expand this model to other states because I think the model is extremely effective. It works. It's a not-for-profit business model. The dentists are paid well, the staffs are paid well, but they are efficient.

They just do a great job of treating patients. I have carte blanche to walk into any one of their clinics at any time because I want to make sure that I'm endorsing a group that does safe, effective, compassionate dentistry. They practice by the book, absolutely by the book. I am very impressed by what they do at Sarrell.

So it can be done.

It absolutely can be done.

One of the issues that comes up [with Sarrell], as they say, this is not a nonprofit; it's a profit-making entity; they're just calling themselves nonprofit. What do you say to that?

I say that it doesn't make any difference. I have to be careful. I am on the board of Sarrell without compensation, so I attend their board meetings and I see information that I really can't discuss. But what I can tell you is that whatever profits they do make are plowed back into the business.

So the Sarrell model, the nonprofit model, focused, you know, like a laser beam on Medicaid. Can that work everywhere?

It can work everywhere. Now, there are some things that are going on here that you need to understand. So they only focus on children, all right. … There's reasonable reimbursement in Alabama for children; most states do not have good reimbursement for adults. That is another problem. And that's where the Federally Qualified community Health Centers [FQHC] can come into play with the reimbursements that they are able to get providing care to adults.

But as you point out, the problem begins at age 1. Going after kids is a worthy goal here.

Absolutely it's a worthy goal. And Sarrell — there is some data that I can share with you from Sarrell. So their oldest clinic is in Anniston, [Ala.] That's about seven years old right now. What has happened in Anniston is that the average annual reimbursement that they receive from Medicaid has absolutely decreased over seven years. Now, does that sound like a for-profit business model? No. Why is that? What we believe that results from is the fact that these children have been getting preventive care.

So the dentists are now switching from filling teeth in those children who have been a part of that Anniston clinic to only providing preventive care because they are preventing disease. And that's with an increase in the number of patients, the average annual costs are decreasing. That sounds like a not-for-profit model to me.

The flipside of this coin are the, you know, private equity firms, the big corporate firms, the Kool Smiles and Aspen [Dental] for adults. Do those models provide any sort of useful service, or is it headed in the wrong direction?

So theoretically those models sound like a terrific model. The dentist doesn't have to worry about management issues and things like that. Unfortunately, what we are hearing is that the dentists are reimbursed in those models on production, the amount of care they provide, not the amount of preventive services that they provide. And therefore we have examples of patients being abused, overtreated in some of those cases.

Well, is it accurate to say that profits and true patient care don't mix?

No, I don't think of that. I don't think that that's true. I think that dentistry is a business, right? There's no doubt about it. It is a business that dentist has to pay the rent [on]. First of the month has to pay the staff, has to pay his or her salary. So the model has to be able to produce profits in order to do that. The difficulty is when the entire motive is profit. When the entire motive is selling dentistry, when the entire motive is selling expensive procedures, that's where the difficulty is. But no, I have no particular problems with the fact that it becomes a business model.

I don't suppose private equity investors on Wall Street would care much about whose mouth is healthier than the other. They care about how many crowns were put in, right?

They care about the bottom line. And that's why they are attractive, and that is why there is concern about these corporate models. However, as I said, ideally they sound good on paper. It's like managed care. Managed care sounds good on paper. The difficulty is that to make money in the managed care, you almost want to discourage patients from coming and utilizing services. And so it's putting

those two together, which is a really difficult thing to implement. Conceptually it works; in practice it's difficult.

There is some good that comes about when a corporate chain reaches somebody who has not been to a dentist at all. That's better than nothing, right?

That is better than nothing if they're providing the right services.

But that's not what we see, is it?

That's not what we are hearing.

How many people are unable, one way or another, either by access, finances, whatever the case may be, how many people are just not able to get to a dentist in this country?

The number we all use is there are about 100 million people that are unable to access care in the regular dental system. That includes patients who are on Medicaid because so few of those Medicaid patients can find a dentist who can take care of them.

Approximately a third of the country?

Approximately one-third of the country. That is where those lines are coming from, those MOM [Mission of Mercy] programs where they line up 24 hours ahead of time. They can't get care anywhere, and so they are willing to wait in line 24 hours for free care even if that free care might only be the extraction of one tooth. They are desperate.

A hundred million people.

"They can't get care anywhere … They are desperate."

Yes. It's a hard number to fathom in this country, the richest country in the world.

So when you look at 100 million people, do we just not have enough dentists, period? I mean, that's a huge number that is just not enough capability no matter what you do.

I'm not expert enough on the numbers to say that we actually do not have enough dentists. What we don't have is a system that allows us to reach those individuals, and that's where we go to the discussion of better utilization of our dental hygienists, better education of the patients, getting the patients into the system earlier.

So let me give you an example. In New Zealand, they have a school-based dental health program. The children don't go to the dentists; the dentists go to the children. They have dental clinics in every school in New Zealand. And now they're reaching down even further to the 1-year-old children equivalent to our WIC programs or our Head Start programs, because they understand you have to reach to them early. … We don't have enough of that in this country.

How important are our teeth? It's more than just a winning smile, isn't it?

It is much more than a winning smile. It's part of our overall health. There is new scientific literature that's showing the relationship, for example, between inflammation of your gums, periodontal disease, and heart health, control of diabetes. The management of diabetes is influenced by the level of periodontal disease, gum disease that patients have.

The ability to chew food, the ability to have a good smile — who is going to hire someone in the sales position that has two or three missing teeth or black holes in their teeth? It's part of a public persona. So teeth are important in a variety of ways.

Why don't our political leaders want to take up this cause?

Well, in Florida they are claiming the state is broke. They are claiming that this is not a high priority. That's the difficulty. It is a priority, but we can't convince them. And to be honest with you, when the dentists have gone to Tallahassee in Florida to lobby for increasing the [Medicaid] fees, then they're accused of being self-serving.

I guess when legislators say we're broke and can't afford it, you should probably show them Trinity Way's hospital bills, and tell them that they're paying it one way or the other. Again, the example I used earlier, 110,000 emergency room visits in Florida in 2010 cost the state or insurers $88 million.

And you could do that for pennies on the dollar.

Pennies on the dollar. Preventive services on Medicaid rates would cost between $50 and $60 a visit.

Pay me now or pay me later.

That's exactly right. And then in addition, you don't have the pain and suffering. You don't have the missed school. You don't have the missed work days. You don't have the potential deaths.

Seems like a win-win?

It would seem to be a win-win except that you just simply can't make the argument. And I'm not going to just say the dental care. We have the same issues in education in this country; we have the same issues in a number of other areas. Pay me now or pay me later. Pay me with inexpensive dollars where you're going to produce a social good or pay me later to incarcerate people in jails, for what?

Meanwhile, oral health in this country, not so good, is it?

It is not so good.

Why is this happening? Is it the diet has changed? What is going on?

So starting around the 1950s, we had water fluoridation going on in this country. The demonstration projects were successful. And what we really saw for the next 30 to 40 years was a decrease in dental caries [cavities], particularly among children — primarily the result of water fluoridation and then putting fluoride in toothpaste, OK.

For whatever reason — and we do not understand the reasons why — somewhere around the '90s we have started to see this rate go up. Is that a

result of poverty? I can't tell you. I don't know. The experts cannot agree on what the cause of that is, but we do know that it is going up.

This is a crisis.

This is a crisis. Sen. Bernie Sanders [I-Vt.] just released a report. "Crisis" was the title of the report in dental health. And we need to fix it. We need to fix this by education, by money and by organizing a new system of care.

Generally nationwide, what are dentists seeing, particularly among poor kids? What are in these mouths, disease?

After all the decades of an improvement in dental health in children because of water fluoridation and fluoridation in toothpaste, we have started to see an increase in dental caries. … Again, I was a practicing pediatric dentist as part of an academic community, and I would see children 10 years ago, 1- and 2- and 3-year-olds coming into our offices with multiple cavities.

So it is on the increase. We're not exactly sure why it is on the increase. But these are real numbers. The numbers in Florida, as an example, 1,200 children a year in Florida get their dental care under general anesthesia in a hospital. That's an enormous number. And those numbers are going up. The waiting list of our dental clinic — six months for a child to get a routine visit if they're not in pain. Six months' waiting list.

OK. So suddenly, a generation ago, it was kind of rare to see cavities, right? There was a sense at one point that we'd sort of eliminated [them], right?

It wasn't rare to see cavities, [but] we had been having success in getting the rates to come down. But you still saw it in the poor part of the population. And that appears to be where the increase is occurring. It is not occurring necessarily in the middle class or the higher socioeconomic group. It is occurring in the poor. We don't know all the reasons why. We just simply don't know. But the numbers are huge, and they're overwhelming the system in terms of the parents being able to find care if they want to find care for those kids.