

Special Care Dentistry Delivers a Formula for Change: A Model Has Been Developed but Must Be Implemented Statewide

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The Reality of Now

Not-so-pretty scenarios are being played out daily in our communities:

- The benefit of a lifetime of dental care rapidly disappears for patients who cannot access a local dentist's office. Longtime dental patients are frequently turned away from practices because of complicating medical conditions, limited mobility, or change in financial status. Lack of on-site care in skilled nursing facilities, group homes, or home health programs forces them to receive only emergency care at best. A lifelong routine of regular checkups and preventive and restorative care is forced to come to an end.
- Unable to clean their own mouths, these compromised residents depend on the facilities or home caretakers for daily preventive care. Almost universally, caretakers shy away from cleaning mouths; they will take care of every other part of the body, but avoid the mouth out of fear that they will hurt the resident or that they will be bitten. What results is a filthy mouth with rapidly progressing root decay and gum disease. It gets worse for the typical dementia, head trauma, or non-communicative stroke patient who cannot say he or she hurts.
- After a few months of little or no oral healthcare, residents are in a constant state of oral infection, a dangerous condition with spin-off effects. Oral bacteria and debris can be aspirated into the lungs, which causes aspiration pneumonia and necessitates costly treatment and trips to the hospital. Diabetics have trouble controlling their disease because of this constant source of infection. Oral bacteria can also enter the blood stream, landing on heart valves and causing infection.
- Families are frustrated with the lack of availability of basic dental care. Caretakers are willing to drive anywhere for help, but help doesn't exist. Those with autism, cerebral palsy, muscular dystrophy, and a dizzying variety of syndromes are left without the hope of care.

Talk to a facility director of nursing, a health coordinator for group homes, or any family member providing care for a home health patient, and you will hear the same scenarios confirmed. Fragile, disabled, dependent North Carolinians deserve better. Luckily a solution is at hand. North Carolina has a tested and proven model of care, the established networks to create a statewide system, and the political will to provide quality, consistent care to its most vulnerable populations.

Four major areas must be considered from a public policy perspective to change this situation.

Table 1.
North Carolina's Rapidly Growing Senior Population

NC ranks 10th among states in the number of persons age 65+.
By 2020, the population 65+ will have grown 71% from the 2000 baseline.
By 2030, there will be 2.2 million 65+ (17.8% of the population).
In 2000, 219,068 persons with disabilities received Medicaid.
Total Nursing Home Residents – 47,336 in over 400 facilities.
Total Group Home Residents (mental/physical disabilities) – 4,520.
Total Home Based Residents (mental/physical disabilities) – 5,364.

A Different Dental Practice and a Provider with a Mission

A new type of dental practice is emerging because of the huge growth in numbers of the older population. To accommodate this demographic and health status shift in the population, the North Carolina Dental Society has initiated a new service area—Special Care Dentistry.

What is it? Special Care Dentistry serves those living in nursing homes, assisted living facilities, group homes, or the community at-large—patients who have intellectual and/or physical disabilities and are medically compromised. There are a few special care practices in the state. This infant area of expertise needs the support of North Carolina's dental care proponents and special care interest organizations in order to expand to serve the state's entire special care population.

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There are two major similarities between a traditional dental practice and a practice dedicated to special care.

- The treatment philosophy is the same. No matter what the disability, all patients deserve the same quality of care that any of us within the community receives.
- The other similarity involves how care is provided. Special Care Dentistry involves the complete dental team—dentist, dental hygienist, dental assistant, and office support staff.

But to be successful, the practice of Special Care Dentistry, whether on a full-time or part-time basis, requires a completely different practice organization.

- For instance, it requires an expanded practice location. Although Special Care Dentistry can be delivered in the fixed-office setting, most special care patients either cannot be easily moved to an office or exhibit behaviors that cannot be managed in a waiting room. Because of this, most patient care takes place at a facility, community center, or in the hospital operating room. Local private practitioners working in a limited number of facilities can provide emergency care and some clinical services, but they cannot provide comprehensive services for the entire special care community.
- It requires different equipment. Equipment needs to be mobile because it needs to go into a variety of settings, such as a long-term care facility, community center, or home. Residents who are sick or who have trache tubes or cumbersome geri-chairs cannot be transported outside to a “Winnebago style” van for care, especially in the middle of winter.
- It requires different reimbursement rates. Because 80% of special care patients depend on Medicaid to pay for their dental care, and Medicaid reimburses at approximately 62% of cost, a special care practice cannot serve the entire community with comprehensive, quality care, and be fiscally sustainable based solely on fee-for-service reimbursement.
- It requires a different legal structure. The most workable structure to emerge is the nonprofit practice. Nonprofit status allows the funding of start-up costs through grants and provides tax deductibility for contributions that help offset the cost of providing care to most patients at Medicaid rates.

Beyond the changes in practice organization and reimbursement, it requires a provider with a specific set of dental and interpersonal skills.

- It requires a different mindset. Direct patient care for special care patients requires more time per patient. It requires special training, flexibility, creativity, and a dedication to serve these difficult patients. In addition, this type of practice is more physically demanding than the traditional practice, both because of moving portable equipment into and out of facilities on a daily basis and treating patients who may be combative.
- It requires extensive communication about care because more individuals are involved in treating or approving treatment plans for the patient. The dental provider in a nursing home works with facility and hospital administrators, physicians, directors of nursing, charge nurses, social workers, other

ancillary providers, a variety of responsible parties, those responsible for the daily oral hygiene of the patient, state facility surveyors, and the patient. Communication with these team members adds extra time to the process.

- It requires attention to detail. The nursing home chart is huge compared to the typical dental chart. Twenty percent of special care patients require conscious sedation for treatment. Conscious sedation monitoring by nurses and the dental team greatly extends treatment time. The long list of drugs these patients are taking requires a specialized knowledge of pharmacology. Treatment forms include a variety of permission requirements for guardian, power of attorney, and healthcare power of attorney.

Formula for Change: Expand the Number of Comprehensive, On-Site Programs

Making excuses for intermittent, less than comprehensive care is unacceptable and degrading to special care patients. To serve the special needs populations, dentistry must expand the recruitment efforts and the number of training opportunities for special care dental providers who will serve all patients, no matter their reimbursement source, location, type of dental care needed, or disability.

The nonprofit practice is the most workable model to date. It is a model that can be expanded to accept special needs patient referrals from local practitioners; serve the rapid influx of retirees to North Carolina; relieve the gap in service to those deinstitutionalized by North Carolina’s mental health hospital system; and support special care patients, families, local health-care providers, and organizations representing the special needs patients.



Access Dental Care mobile equipment and truck.

Changes Require a New Breed of Community Practitioner

The growth of this special needs population requires a dental team with special training. Until recently, the few practitioners providing comprehensive special care worked at the University of North Carolina at Chapel Hill (UNC-Chapel Hill) School

Special Care Dental Programs

North Carolina's Special Care Dentistry programs emerged in the late 1990s and have created a sample framework for a statewide system.

- In the mid-1980s, The North Carolina Dental Society created a special care committee to address the treatment needs of patients and education needs of providers.
- In 1997, this committee supported the development of Carolinas Mobile Dentistry (CMD) at Carolinas HealthCare System, Charlotte. It began service to nursing homes in the Charlotte area. CMD covers 1,800 beds.
- In 2000, the North Carolina Dental Society initiated Access Dental Care. This Greensboro non-profit assisted Wake Forest University Baptist Medical Center (WFUBMC) in creating their Special Needs/Portable Dentistry program in 2002. It also teamed with Healthy Cabarrus, Kannapolis to start a branch of Access Dental Care in a four-county region around Concord/ Kannapolis. Access Dental Care has now absorbed the WFUBMC program to serve 4,000 beds and plans an expansion of service to the Triangle region.
- By 2006, the Carolinas Mobile Dentistry and Access Dental Care programs will cover over 7,000 beds.

Table 2.
Access Dental Care Five-Year Summary

Totals from August, 2000 – July, 2005*

Clinical

- 3702 Total Patients in the Practice
- 19,505 Total Patient Visits
- 32,116 Patient Services Provided

Financial

- \$2,815,966 billed with an average gross of \$98 per patient.
- \$1,908,824 paid to date
- Over \$903,000 in uncompensated care provided. This amounts to almost two years of net revenue. (80% of our patients are Medicaid beneficiaries)
- 162 Operating Room Patients (MR/DD patients-Medicaid) with an average gross of \$1350 per patient.

*Figures do not include the newly acquired WFUBMC program.

of Dentistry, in a limited number of hospital dentistry programs, in the state mental retardation hospital system, or in a local private pediatric practice. A few private practice dentists go to a limited number of nursing facilities on their "day off;" most work with few dental staff and carry basic portable equipment. Unfortunately, none of these is sufficient for today's special care dental treatment needs.

The UNC-Chapel Hill School of Dentistry is, first and foremost, a teaching center, not an access to care facility. Its staff's expertise has made it the default special care referral source over the years for local practitioners. The special care population has grown so rapidly and is so difficult to transport that the school cannot continue to provide statewide access to care. To complicate matters, the School of Dentistry has experienced decreases in public funding, limiting its ability to start new teaching programs targeting special care populations. This means that neither dental school students nor faculty members have the opportunity to learn how to treat special needs populations in the community setting. If dental students are not introduced early in the education process to delivering care in community on-site programs, we lose the opportunity to put future practitioners into the special care professional pipeline.

State mental hospital dental staff experience on-the-job training because they handle North Carolina's toughest cognitively disabled patients daily. But, a few years ago, North Carolina decided to initiate a program of de-institutionalization, placing many of these severely and profoundly handicapped residents back into community group homes. Now group home programs are desperately seeking local dental care for these residents, arguably the most difficult to treat in dentistry. Communities without special care providers have no resources to call on.

Some larger hospitals have dentists on staff and/or graduate training programs that care for special care residents, primarily in the operating room setting. These dental teams are also responsible for in-house physician referrals, preparing patients for surgery, and providing oral care to support cancer therapy. To this point, they are at capacity providing in-house care and have not been able to expand to on-site community programs.

There are some dentists providing limited care to long-term care residents. Because of the extreme shortage of comprehensive special care programs, facilities contract with these providers knowing that many of their residents will not get the care they need. Mass examinations are followed by some extractions and denture work. Treatment plans for the remaining residents are provided, and the facility is required to find a dentist willing to provide care. This is a dead-end referral because most local dentists are not trained to deal with these patients.

Some local dentists will continue to treat some special care patients. Pediatric dentists still care for children with disabilities, but their practice volumes have forced them to restrict the number of older special care patients they see. General practitioners have an important role in caring for early dementia patients and the manageable chronically ill.

Formula for Change: Special Care Professional Education

A new model of care requires a new program of education for dental providers. At this point, North Carolina does not have a program that trains special care providers. Short student rotations and courses at the UNC-Chapel Hill School of Dentistry provide exposure to the special care patient, but do not provide the formal training necessary to enter an active practice. A post-graduate residency would allow dentists and hygienists to gain across-the-board dental skills provided in fixed, mobile, and hospital settings. Education for current local practitioners interested in Special Care Dentistry can be supplied by mini-residencies, regular continuing education, and on-site practical experiences.

Residents and their families are asking legitimate questions about the lack of daily oral care. Facility administrators and directors of nursing must finally make oral health and daily oral hygiene a priority. When this happens, special care dental staff can train the facilities' admitting nurses and education coordinators, who can, in turn, maintain a consistent teaching and monitoring process of direct care staff. Charge nurses and nursing aides must understand the ramifications of not providing daily oral hygiene and be held accountable. Failure to do this will, at some time in the future, put the facility at risk (e.g., families will take legal action).

There are a few existing education programs that need to continue. North Carolina Division of Facility Services surveyors, those in charge of ensuring that federal and state Medicaid funds are spent wisely, receive regular training. This training should be expanded to include other long-term care advocacy groups. Future facility administrators are provided oral health programming information during the North Carolina School of Public Health Administrator in Training course. Every future administrator knows what a comprehensive dental program looks like. University interdisciplinary training should continue giving various future healthcare providers an understanding of oral health issues.

Funding that Matches the Practice

As it is currently structured, Medicaid reimbursement does not address the unique practice nature of special care dental services. Many services required by these patients are not even deemed eligible for reimbursement. Right now, 75-80% of skilled nursing home residents and almost all group home residents depend on Medicaid to reimburse their medical and dental providers.

To correct this inequity and to draw more practitioners into special care practice, higher reimbursement rates must be implemented, taking the following factors into account for special care patients.

- Special care patients take longer to treat. Their behavior must be handled before their dental needs can be treated. All of this requires working with the gamut of care givers and responsible parties. This takes more time that is not

reimbursed and allows fewer patients to be treated in a day. (Access Dental Care currently averages 15 patients per day) For example, the autistic patient requires a special treatment regime and environment. It takes many appointments to gain the patient's trust, none of which are reimbursable. The treatment setting must be quiet, consistent, and supportive of parents.

- Patients with special care needs require more expertise to treat. Each new employee, dentist, or auxiliary must spend six months to one year learning to care for these individuals. None of this training experience is reimbursable to organizations.
- On-site programs require travel time and expenses, none of which is reimbursed. Access Dental Care fuel costs have doubled in the past five years. Each team spends approximately two hours each day going to a facility, setting up the dental equipment, breaking down the dental equipment, and returning to the administrative office.
- Communication with responsible parties takes time and is not reimbursed.

Public funding of dental services for the truly needy and vulnerable populations continues to be a problem. Historically dentistry has received 1-2% of total Medicaid funding, and now, in North Carolina, Dental Medicaid rates reimburse at 62 cents on the 2001 dollar. A lawsuit several years ago increased Medicaid rates by 12%, but inflation has now neutralized these gains with no sign of significant increases in the future. Although the overall population is increasing dramatically, the relative numbers of the special needs population are small, and what might seem to be a large increase in reimbursement rates would actually result in a relatively small increase in overall expenditures.

Formula for Change: Innovative Funding of Special Care Dentistry

Existing special care programs have been created through "grassroots" community efforts, with initial funding from grant support. Generous seed money from several North Carolina foundations is the reason for Special Care Dentistry's successful programming to date. Medicaid's inclusion of adult services has given providers the chance to deliver comprehensive care. There is ample financial data to craft an expanded list of reimbursable services for Special Care Dentistry. It should include funding for education priorities, public policy initiatives, program development, and fair fee-for-service reimbursement.

Public Policy Initiatives

Starting a new field of service delivery involves creating a new structure of practice. Old rules must be reviewed, present practices changed to improve service, and future programs created to deal with a changing population. Special care providers are currently treating patients five to six days a week plus trying to develop awareness of special needs in education, research, local program building, and public policy development. It is an overwhelming

task. This core of individuals has the expertise to manage this change process, but they need the time. Unfortunately, the present organizations operate on such a thin profit margin, any time spent not treating patients puts them at financial risk. The following action areas need to be implemented.

- Provide support for long-term care provider organizations to establish consistent, quality Special Care Dentistry services.
- Work with communities wanting their own special care dental program. Several North Carolina communities are requesting help, but there is no time available to help them develop a program.
- Create health services research projects that support the development of community programs and ensure the quality of care provided.
- Review North Carolina's existing dental practice laws to allow for the more efficient practice of Special Care Dentistry.

Formula for Change: A Special Care Dentistry Center

Fund a North Carolina Special Care Dentistry Center to coordinate the activities mentioned in this commentary. A part-time dentist, a hygienist, and an office assistant can bring together the necessary parties to do the job right. Funding must be sustainable, giving this group the chance to work on the necessary issues and not spend all their time raising money.

Our Next Step

Many North Carolina foundations, the North Carolina Dental Society, long-term care organizations, individual nursing/group homes, and responsible parties of the mentally and physically disabled have "put their money where their mouths are." North Carolina's long-term care organizations understand the need for change and are asking special care dental providers what they can do to help create a statewide system. Dentistry has developed a successful model for providing care, but now needs the support of other organizations that will benefit from these changes. It is time to agree on a workable business/policy plan and make sure that specific changes are made. North Carolina's future long-term care residents deserve a better quality of life—one that puts the mouth back into the body. **NCMedJ**

For More Information:

To learn more about Access Dental Care and Carolinas Mobile Dentistry, visit their Web pages.

Access Dental Care

www.accessdentalcare.org

Carolinas Mobile Dentistry

www.carolinas.org/services/seniorcare/mobiledentistry.cfm



Caregivers Don't Need To Do This Alone!

- ◆ Significant increase in the number of persons providing care to a friend or family member age 60 or older from 2000 to 2003
- ◆ Over 25% of adult North Carolinians now provide care to an older friend or relative
- ◆ Almost half of those receiving care are reported to have memory loss or dementia

Many people need the support of others who are in similar situations or perhaps the support of a professional. They may need education on caregiving issues. Caregivers may need respite or a "time-out" from their caregiving duties. Seeking information on what services are available and assistance to help connect with these services can be an important first step.

North Carolina Family Caregiver Support Program
<http://www.dhhs.state.nc.us/aging>