INSTITUTE FOR Oral Health

Oral Health Needs for Seniors, Pt. 2

Bringing Innovation to Dental Education, Care and Access for Aging Adults

WHITEPAPER

Institute for Oral Health 2008 Focus Groups

on “Oral Health in Aging America”

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Introduction

> "*With the elderly, the most important things that need to be picked up can only be picked up by a trained professional. It's more of a duty on the health care system to proactively think about who is at risk, why they are at risk, and what are the consequences.*"
>
> *–Dr. Michael Helgeson*

In the dental industry and beyond, there is a forgotten, even avoided, generation: ***the elderly.*** Aging adults often do not get care due to inadequate insurance, low income, dependence on assisted living, or quite often, they simply do not recognize problems or realize how important good oral health is to their own longevity and quality of life. In turn, many dental providers have too little access to senior patients and are untrained and ill-equipped to manage the complexities of special needs care; many are uncomfortable with the elderly and avoid treating them. Yet, with the baby boomer generation now entering retirement age, many dentists will be seeing an increase of aging adults in their practice, and they need to be prepared,

To help them get there, Institute for Oral Health (IOH) is dedicated to collaborating with providers of both care and coverage to diseminate education and influence the effectiveness of how dental care is delivered in order to meet the needs of all Americans. This year, IOH spotlights "**Oral Health in Aging America**", an issue of increasingly critical concern, promoting relevant news and research, and raising awareness through our website, newsletters, and an annual national conference to be held in September 2008. To help identify the most important issues needing attention, IOH hosted two focus groups with the nation's leading authorities in geriatric dentistry. Details from the second group, hosted in June 2008 in Denver, CO are summarized in this paper.

Participating in June's focus group discussion were five nationally recognized experts in geriatric dentistry and dental care for special needs patients. They shared presentations on specific topics and collaborated in open forum discussion. Unanimously, the experts agreed that the dental industry needs to place a far greater emphasis on the importance of providing qualified care to the growing numbers of senior patients. Indeed many older adults have difficulty affording dental treatment, but access to care is only part of the problem looming in the dental profession today. Increasingly, everyday dental practice will be facing unique challenges as patients age, including medical complications, cognitive difficulties, more time-consuming care requirements, and severe oral health neglect –and far too few providers are adequately trained to effectively support the special needs of aging patients.

Along with Institute for Oral Health Executive Director, Dr. Ron Inge, the group targeted key concerns and opportunities in geriatric oral health care today, including:

- Preparing for the challenges of treating seniors – Issues and needs associated with treating aging adults, and the kinds of education, training, and even economic models that dental providers should look into getting in order to better support senior patients in their practice.
- Improving access to care for seniors – A variety of progressive dental plan solutions that could benefit low income elderly, and help working individuals plan effectively for their senior years.
- Increasing effectiveness through collaborative practices – Delivery of dental care to elderly patients is greatly advanced through partnerships between private practitioners and community facilities such as nursing homes and assisted living. Collaborating teams of well-trained experts can treat a greater number of senior patients, more efficiently and cost-effectively.

About Institute for Oral Health

The Institute for Oral Health is dedicated to improving oral health in America by bridging the gap between research and everyday dental practice. Serving as a central resource for education and collaboration, IOH brings together nationally recognized experts to focus on important themes of concern in oral health care today, and works to promote innovation and adoption of progressive treatment guidelines, dental plans, and delivery methods. For more information, please visit online at: **www.iohwa.org**.

Panel Presentations

Stephen Shuman, DDS, MS

Associate Professor & Director, Oral Health Services for Older Adults Program, Univ. of Minnesota School of Dentistry

Riding the Age Wave: Changes & Challenges for Dental Professionals

Dr. Stephen Shuman focuses his teaching, research and clinical practice on the special challenges of geriatric oral health care. In the June 2008 IOH focus group, he provided valuable background on what's happening in the senior population that is raising so much concern for the dental profession.

Key Population Changes That Will Impact Dental Professionals

Dr. Shuman began by highlighting important statistics on how our nation's older population is changing rapidly, and how this will affect everyday dental practice in the coming years:

- Dramatic increase in seniors – Based on estimates from the U.S. Census Bureau, the millions of adults over age 65 will be increasing dramatically over the next 40 years (76 million baby boomers start turning 65 in 2011). Dr. Shuman cautions his graduating students that when they reach the peak of their practice about 20 years from now, there will be over 70 million Americans aged 65 and older; an indication of who they will be dealing with in their practice.
- Longer life expectancies – Although U.S. life expectancies are actually extending, many adults over 75 hold the perception that they won't live much longer. As such, when getting dental treatment, they often request simpler, less expensive solutions that later fail as the patient goes on living to a ripe old age. To effectively counter this problem, it's a good idea to educate elderly patients on both the treatment options and longevity data –this helps people better understand how long certain solutions are likely to last so they can make decisions that support them better over the long term.
- The rural age boom – Statistics show rapid growth in the proportion of adults 65 and over, many of whom may have less access to dental care, particularly in rural communities. This rural segment is quite often underserved due to lack of income, insurance, and availability of dental resources skilled in geriatric care.

Understanding the Uniqueness of Elderly Patients

A common perception is that all elderly people, particularly those over 80, are basically alike. On the contrary, as people grow older, they become even more different from one another. For example:

- Accumulated differences – As they age, each person accumulates an unique set of life experiences, health and lifestyle influences, behaviors, and disease exposures. These differences present greater challenges to geriatric dental practice as it means expanding skill sets and facilities, and providing very individualized care.

- Varying functional status – Increasingly, older adults are maintaining healthier functional status longer. On the one hand, that makes geriatric dental care easier. However, this may be offset by the sheer volume of senior patients. The rapid growth in the senior population means dental professionals will see an increasing number of aging patients with varying degrees of functional and cognitive ability

- Rapid growth in diversity – 2006 study estimates that by 2050, in populations aged 65 and over, the "white only" segment will drop by 20%, with Hispanic seniors increasing by 12%, Asians by 5%, and other races growing by 2-3%. This indicates that not only will dental professionals need to be competent in providing geriatric care, they need to be experienced and flexible in providing care to people of diverse backgrounds, including working with language interpreters.

The New Elderly with Old Problems

Many people, including seniors themselves, have the perception that getting older means losing teeth. However, with today's healthier lifestyles, medical and dental advances, and longer life spans, many older adults are keeping their teeth and have a greater need for regular dental services. With a growing number of geriatric patients in their practice, dental professionals need to be aware of some common problems, including:

- Higher caries rate – Over the years, Dr. Shuman has found that, by far, the most prevalent dental problem in his geriatric patients is root caries and related restorative problems. As more and more elderly patients maintain their natural dentition, they have basically "*outlived their risk of periodontal disease, with most of those patients already into dentures.*" As such, many geriatric patients will lose their teeth not to periodontal disease but to caries and restorative complications. In fact, a 2004 study showed the annual incidence of root caries in US older adults was nearly 24%, and the overall caries rate (root plus coronal decay) was comparable to the crisis of cavities in children.

- Increases in oral cancer – Age increases the risk and incidence of oral cancer, with each year now bringing 34,000 newly diagnosed cases and 8,000 deaths. Now consider that in the population over 65, the risk of oral cancer is seven times higher, with 75% occurring in long-term users of tobacco, alcohol or both.

- Impact of chronic medical conditions – Providers can expect to see many older patients with medical concerns and medications that must be factored into their dental treatment plans. A 2006 study from the Center for Disease Control cited 54% of women over 65 have hypertension; 37% of men have chronic heart disease; many seniors have arthritis (43% in men; 54% in women), and so on. These conditions often increase the complexities of dental care, so dental professionals need to be prepared to accommodate them.

- Dealing with dementia – One of the most perplexing problems for dental providers is dementia, a highly prevalent condition now estinated to affect up to 50% of adults over age 85 and 13% of those over 65, according to 2007 statistics from the Alzheimer's Association.

  In Dr. Shuman's seniors clinics, nearly 50-60% of the patients are affected by this in some way. Surprisingly, 70% of dementia patients live at home, not in assisted living, and thus, "*they will need care from community practitioners who may or may not know what they're dealing with*."

  "1 out of every 2 people who are 85 and over may have some cognitive problems. We have to be aware of that as it's going to have a huge impact on their care needs."

Of special concern with elderly patients, especially those with dementia, is that their medical and psychosocial needs often become so great that dental care "falls off the radar" for long periods. By the time dental providers can intervene, problems may have grown severe, and the patient's frail condition makes treatment extremely difficult. These scenarios are typical of what's happening across our senior population and provide a strong indicator of what dental care providers need to be prepared to handle.

Dealing With Polymedicated Seniors

Yet another issue to consider in geriatric dentistry is the widespread use of medications by older adults. Dr. Shuman cited some important studies that highlight the impact this has on geriatric dentistry:

- Rising incidence in drug utilization – A 2003 FDA study cites that, on average, seniors take up to nine medications; there was a 45% increase in drug utilization from 1992 to 2000, and we can expect a 35% increase by 2010. Additionally, adverse drug events may affect 20-54% of older adults.

- Impact on geriatric dental care – Often these medications have side effects that affect a patient's dental condition such as complications from dry mouth, soft tissue pathology, and periodontal problems. Additionally, the drugs can even impair balance and cognitive function, or cause circulation problems, ulcers, and infections, such as jaw osteonecrosis related to the mediations for osteoporosis. Dr. Shuman cited patients on even commonly used pain or antianxiety medications who, after dental treatment, have fallen and been seriously injured as a result of losing their balance.

How Big Is the Problem of Access?

It's very severe. More seniors than ever before are struggling with little or no dental insurance, and nursing home needs and expenses will skyrocket over the next 20 years. Dr. Shuman noted some alarming statistics, including:

- As of 2001, among adults age 65 and over, nearly 68% were uninsured; 22% were covered by private insurance; and only 7% had public coverage. Hardest hit are seniors living in rural communities where dental insurance is less available (72% rural uninsured vs. 66% urban uninsured). Private insurance numbers are slowly going up, partly due to people working longer and retaining their benefits instead of retiring at 65. (NHIS/NCHS, 1997-8, 2001).

- In that same study, nearly 50% of seniors went to the dentist only when they perceived a need. In itself, this in highly problematic… there is often a big discrepancy between what providers know older adults need in terms of dental care and what the patients think they need. Thus, too often older patients do not see a dentist until after a condition has deteriorated enough to really bother them –and at that point, restoration options are more limited, more complicated, and more expensive.

- Over the past 30 years, though national income levels are rising across adults 65 and over, as of 2002 we still had 40% with low or poverty level income, which is a very substantial amount of our older population. (U.S. Census Bureau, 2003)

"40% of people over 65 are at the low income or poverty level – 10% are in poverty. How are we going to get dental care to these people?"

- Studies cite that 43-50% of those 65 and older will spend some time in a nursing home during the remainder of their lifetime. Nearly 40% of these facilities across the nation have no contract for dental services, and dental care is one of the least used, with only 26% of residents using dental services compared to 91% for medical services. Yet nursing homes are full of people at high risk for oral disease and regular dental care could make a big difference in their overall health as well. (Spillman & Lubitz, 2002; CDC/NNHS, 1999, 2004)

Furthermore, with an increasing number of options available for long-term care for semi-dependent and dependent elderly, there is more likelihood that seniors will be in less regulated facilities where dental care may be ignored. Therefore, dental professionals can expect that, if and when they do see elderly people from long-term care, they'll be dealing with patients whose oral condition may look like "a train wreck" and their overall health may have severely as well.

The Positive Impact of Seniors Using Dental Services

Despite the dismaying statistics around dental care access for seniors, there is a bright side. According to a 2004 National Oral Health study by the Center for Disease Control, in the U.S. population age 65 and older, about 66% reported they had visited a dentist. Also promising was that the number of people who had lost all their teeth was down to about 20% in 2004, and those who had lost six or more teeth was down to about 47%. Also good news is that, between 1988 and 1998, senior dental visits rose 3.5%. (Meskin & Berg study, 1988-99). These promising numbers open up new opportunities for today's dental practice, such as:

- Increased practice profitability – Despite the complexities of providing care to older adults, this age group can have a positive impact on practice economics. Patient expenditures among seniors has risen steadily over 10 years. Between 1988-1998, while expenditures for younger patients (age 20-39) decreased over 9%, the senior care expenditures increased over 3%, and represented nearly 30% of total patient expenditures. As geriatric patients often require more sophisticated dental services, appropriately trained dentists can increase the profitability of their practice by serving older adults.

- Expanded patient base – Providers who typically wait for their practice to "age with them" should consider marketing to older adults who need and want quality services.

- Development of special needs expertise – Providers could more effectively and efficiently serve older adults already in their practices by increasing their preparation and understanding of the special needs and preferences of these patients. With baby-boomer seniors, dental professionals can expect to see more patients who've retained their natural teeth and who will want a full range of services provided on demand.

Dr. Shuman encourages the dental profession to recognize the many challenges of serving an aging society –financing, adequate training, caring for diverse and rural communities, educating seniors and health care partners— and work together to create, implement and promote solutions as broadly and quickly as possible.

Judith Jones, DMD, MPH, MS
Professor and Chair, Dept of General Dentistry, Boston University School of Dental Medicine and Associate Professor of Health Services in the School of Public Health

The Cost of Care and Who Pays For It

For the June 2008 IOH focus group, Dr. Judith Jones brought years of experience in strategic planning and development for dental education and delivery based on patient-oriented research, particularly in long-term oral health care. Her presentation focused on the economic picture, and innovative dental plans that support both broader coverage for seniors and more effective reimbursement for geriatric dentists.

The Financial Big Picture

In adults age 65 and over, some trends look promising: over the past 30 years, use of dental care has increased from 30% to 58%. In fact, the increases are much greater in this age group than any other, in part due to changes in oral health status and the value placed on maintaining good oral health. (NCHS) However, there are a number of serious concerns that need to be considered, including:

- Low incomes – 2007 surveys show that 75% of older adults have an income less than $50,000 per year, which is not much to live on these days, especially when your medical and dental health demands greater attention.
- Exorbitant national health expenditures – As of 2005, our nation spends $2 trillion on health care, and yet dental represents less than 5% of that spending. Even so, dental care spending, at $87 billion in 2005, is already approaching $100 billion.
- Sources of provider reimbursement – Nearly 90% of medical services are reimbursed by private or public health sources, with only 10% paid out-of-pocket by patients. (Health, 2007) However, for dental services, only 56% is paid by private and public sources, with 44% paid out of pocket –which, based on the income estimates above, represents a significant hardship for older adults. (CMS, 2004).
- Health benefits literacy in older adults – A factor in improving access to care is to emphasize the importance of having seniors educate themselves on what kind of coverage they have so they can make better decisions about treatment options.

"Too often, seniors don't really understand their dental plan, and that confusion interferes with the kind of care and follow-up they get."

The Complexities of Eliminating "The-Uninsured"

According to the Institute of Medicine (IOM), oral health care coverage should be universal, continuous, affordable, and promote well being in all individuals and families. Sounds great, but it is not that simple. To achieve these goals, there are many variables that impact the overall financial picture, including:

- Universal care – What type of coverage is it? Are individuals required to obtain coverage and must employers offer it? Who is eligible and are there subsidies for low income elders?
- Continuous care – Is re-enrollment required and how often? What happens when people change jobs or income levels? Does coverage continue into retirement?

- Affordable care – This goal is especially complex... What are the premiums, co-payments and deductibles? Do they vary based on income, health status, and living facility? Do seniors have to pay and are there subsidies for them? In making this model sustainable, how realistic are estimates of use and costs, and what happens in unstable economic times? Are use and cost controls built in? Do benefits plans encourage simplistic or cost-effective services?

- Care that promotes well being – Is the care high quality, safe and effective, efficient and patient-centered? Are preventive services covered and encouraged? Are there incentives to avoid overuse of services?

It's complicated, not just financially, but also logistically, politically, and ethically. Yet there are positive payoffs for both patients and providers, so how do we move toward the goal of providing dental care for everyone – in particular, older adults? To start innovating change, Dr. Jones enlisted dental industry experts to envision the new health plan scenarios, some of which are detailed as follows.

Solution Scenario 1: State-wide Elder's Oral Health Insurance Program

Using the federally-funded SCHIP (State Children's Health Insurance Program) as a model, a potential solution was proposed that would support seniors. Highlights include:

- Plan sponsorship & development – Funded as a federal state program; developed from legislation with plans varying within and between states; and optional for states to implement.

- Who is covered and who pays? – Targets seniors below and up to 125% of the poverty level, which, as of 2002, would be 6 million people. As this age group has few resources to pay, federal and state funding would be needed, though small premiums and minimal co-pays could be charged to the "near-poor".

- Level of coverage – As the senior population will likely have greater untreated needs, the level of care covered will have a major effect on costs. Ideally, the plan would cover diagnostic and preventive services, basic restorative and emergency services.

This plan is potentially very viable; for example, at 40% utilization funded at $300 per user/year, premiums could be as low as $10 per month. It would also allow seniors the flexibility to tap other financial sources to help them get the care they need, rather than being restricted by coverage limitations such as those under Medicaid. And, by distributing cost across federal and state resources, more practitioners might be encouraged to devote time to senior patients. The downside is that enrollment and eligibility complications could increase costs; and by separating it from medical coverage, "*it perpetuates the misperception that oral health care is not a mainstream part of health care*."

Solution Scenario 2: Prepaid Insurance Plans

Another potential solution considers a program whereby working individuals could prepay into an insurance plan and later use the benefits after retirement. Highlights include:

- Plan sponsorship & development – Funded by major insurance plans or financial institutions such as Washington Dental Service; voluntary for groups and employers.

- Who is covered and who pays? – Currently insured individuals could pay into the plan, with no cost after retirement. Though not configured with subsidies, they could be integrated. Premiums/deductibles/co-payments would follow the typical 100/80/50 or 100/100/50 models.

- Plan management and sustainability – Program could be administered efficiently by expert organizations, with usage and cost controls built in, similar to standard coverage plans.

A great advantage to this program is it could be widely available, easy to administer, and help people plan (while at the peak of their earning potential) for a future on a fixed income, and remove some access to care barriers in old age. However, the plan has a limited market as it requires an additional investment from individuals.

Worth noting is that this program was developed by Dr. Max Anderson while he served as Dental Director and vice president at Washington Dental Service (WDS), a position now held by IOH's Dr. Ron Inge. Although in the past WDS did not initiate the program, Dr. Inge agreed it's worth pursuing again.

Solution Scenario 3: Medicare-supported Dental Care

- PPO – Yet another potential solution looks at how Medicare could be adapted to better support dental care for seniors. Key benefits of a PPO would include services at reasonable cost with a wide selection of providers; and special options and subsidies for low income people.
- Health Savings Accounts (HSA) – Elder-specialized HSA's (tax-free savings accounts specifically used for health care expenses) could be adapted to support high out-of-pocket expenses, with special options for low income persons and supplemental coverage from Medicare.

Solution Scenario 4: Voluntary, Self-Insured Dental Programs

As most dental insurance stops at retirement, Delta Dental developed solutions for targeted groups that provide coverage after retirement. One example is the TRICARE Retiree Dental Program, developed for retired military and their families. The plan, which provides good coverage for restorative and other services from a wide selection of providers. The drawback to the program is that it is limited to this select group.

The Best Solution is a "Mosaic" of Solutions

While there is no one perfect plan, there are many we can draw from in trying to create a comprehensive solution that works for everyone. As Dr. Jones emphasized in closing:

> *"It's going to take a mosaic of reimbursement mechanisms to get care to all elders who want care. The percent of the elder population that's going to want care is only going to increase dramatically with the aging of the boomers. There's also the poor and near-poor who need more assistance. It's incumbent on society to think of those who are less fortunate and include them in a plan that makes sense."*

Michael Helgeson, DDS
Co-Founder and CEO of Apple Tree Dental, Minnesota; Past President, Special Care Dentistry Association and American Society for Geriatric Dentistry; Clinical Assistant Professor, University of Minnesota School of Dentistry

Community Collaborative Practice: Delivering Oral Health Services to Seniors

Dr. Michael Helgeson has dedicated his career to bringing quality dental care to underserved populations including those who can't afford or access treatment such as the sick, disabled and elderly. As co-founder of Apple Tree Dental, he has helped provide services and develop innovative delivery systems to treat over 60,000 people, including 30,000 in nursing and assisted living facilities.

In the June 2008 IOH focus group, Dr. Helgeson highlighted strategies that reframe the perspective of how to address challenges in dental care delivery and approach solutions more proactively.

Breaking the Barriers to Care Delivery

Inspired by his grandfather, a small town doctor who believed "*the youngest, oldest, and poorest in town all deserve heath care*," Dr. Helgeson's work embraces that notion on a much larger scale. With our nation's total population at nearly 300 million people, studies show that nearly 30% of Americans (82 million) are underserved, often neglecting dental care due to economic or medical challenges. 47 million people are uninsured, and even more are underinsured. Although there is no easy solution to get care to all these people, Dr. Helgeson believes that it starts by raising awareness in the health care community about what *real people experience when they cannot get adequate care*. Seeing the risks people are forced to take with their health can be a powerful incentive to drive progressive solutions.

To emphasize this idea, Dr. Helgeson highlighted the success of RAM (Remote Access Medical), a nonprofit organization comprised of an international group of doctors and dentists, who bring services to thousands of needy Americans. RAM originally directed its efforts in third world countries, but due to overwhelming demand, now provides 60% of its services across urban and rural America.

While RAM volunteers often provide care for as many as 600 people in a day, they estimate there are hundreds of thousands more people who need help and can't get it.

On any given day, hundreds of people flock to their mobile clinics for a chance to get care (but with no guarantee) –and these are not the rural poor, they are typically working families who don't have adequate insurance.

Moving Mountains With a Little Prevention

Dr. Helgeson noted that every dental practitioner can start making a difference by raising community awareness on preventive solutions. As an example, he cited a study from the University of Buffalo in New York that established a direct link between oral health and potentially fatal pneumonia in nursing home patients; DNA evidence showed the majority of patients often developed pneumonia as a result of dental plaque. In response, Dr. Helgeson's clinics have promoted educational materials that encourage nursing homes to help patients brush their teeth and dentures to reduce the risk of systemic diseases.

Sometimes these very simple preventive measures can make a significant difference. A Minnesota hospital dramatically reduced its pneumonia mortality rate by having nurses regularly clean the teeth of ICU patients. As a result, the hospital dramatically reduced its pneumonia mortality rate. This success story represents how a substantial, positive change was accomplished by dental professionals raising awareness in the medical community. This kind of collaboration, along with expanding everyday dental practice to include more proactive health education, can help the dental industry make advances toward serving millions of people (even indirectly) who might otherwise never get dental care.

Why Early Detection Often Fails with the Elderly

Dr. Helgeson stated that a key to improving dental care for aging adults is to focus on early warning signs of oral disease and reaching patients before problems arise. In particular, early detection and prevention of periodontal disease can reduce the risk of cardiovascular disease and stroke. Additionally, the October 2007 issue of the Journal of the ADA (JADA) featured research citing the rate of loss of teeth as a risk factor for the development of Alzheimer's. So, why is early detection breaking down with many elderly people?

Because the "early warning system" often fails with older people –particularly frail elders. For example:

- As teeth age, the nerves become less sensitive. Thus, by the time a condition becomes painful enough to see a dentist, both the oral disease and accompanying risks to systemic health are much more severe, and treatment options more limited.
- Patients with cognitive impairments often can't self-check to determine whether they need dental care, and instead later act out when they experience dental infection. As a result, providing care becomes more difficult, and also more costly as these dental infections "*trigger lots and lots of medical interventions*."

As such, a proactive effort of promoting and initiating regular dental assessments in the elderly is essential to the early detection necessary to reduce health risks and health care costs.

Comparing Access to Care vs. Use of Care

How do we make sure the elderly are getting help? It's not all about lack of insurance or income. Part of the problem is the discrepancy between what providers think is needed and what a typical senior patient thinks they need. So, even when care is accessible and maybe even affordable, is it being used? Some important factors that influence the use of dental resources include:

- Demographics – Urban vs. rural environment, race, gender, education, and dentate status.
- Availability of skilled providers – Need dentists competent in the special care needs of the elderly.
- Accessible offices – Need dental offices equipped to accommodate accessibility needs such as lifts, space for wheelchairs, etc. for disabled and frail patients.
- On-site services capability – Need practices that can deliver services to patient home environments such as nursing homes and assisted living facilities.

"With the elderly, the most important things that need to be picked up can only be picked up by a trained professional. So it's more of a duty on the health care system to proactively think about who's at risk, why are they at risk, and what are the consequences."

Improving Access & Use with a Collaborative Approach

Dr. Helgeson noted that the practice of dentistry has not changed much in over 100 years in that it is very insular; typically an individual patient visits an individual doctor in a private office. Yet to effectively solve the problem of access and use for underserved populations, a new system of care is needed to extend the reach of dentistry beyond the dental office. Community Collaborative Practice introduces an innovative model that provides new ways of collecting information and working in teams, and new strategies for getting private offices into teamwork with other organizations and individuals.

The focus is to encourage private dental organizations to collaborate with community partners such as nursing homes, senior assisted living, and schools, and to have a third-party oral health team that mediates care between the community site and the dental office. While those 82 million underserved people face common barriers to access such as lack of knowledge to seek care, financial constraints, and complicated health status, Community Collaborative Practice (CCP) successfully overcomes those challenges, serving tens of thousands of needy people by delivering:

- Early education and prevention – Reaching patients throughout the community before dental problems arise.
- On-site special needs care – Delivering care in patient home environments to ensure access and use, as well as increasing patient comfort, which in turn reduces the difficulty, time and cost of providing care.
- Financial resources – As a non-profit organization, CCP leverages financing from across the whole community including health, education and social services providers, government and philanthropists.

Increasing Effectiveness with Phased Care Programs for Elders

For on-site care delivery, Community Collaborative Practice employs mobile units that can set up a long-term, high-end dental facility in any location such as a nursing home, enabling dentists to serve many seniors who would otherwise not get dental care and potentially suffer greater medical risks. To ensure the most effective care delivery in these on-site locations, the CCP model uses a program for providing specific types of care in specific phases over time, including:

- I – Oral Health Education – At patient admission, re-admission (e.g., after hospitalization), and annually, an Oral Health Practitioner educates elders and caregivers, and conducts assessments. This consistency ensures every patient gets screened and educated about their oral health.
- II – Prevention & Daily Oral Care Planning – Support of proactive dental care such as fluoride varnishes and consistent daily maintenance.
- III – Minimum Data Set Assessment – Screening and assessment system to monitor patient oral health and nutritional status.
- IV – Elders with Disease Identified – The first three phases provide valuable information that helps dental providers triage the urgency of care across all patients.

The Evolution & Benefits of Collaborative Care Delivery

Originally these collaborative relationships were established with dentists as consultants to elder care facilities. But this still presented the problem wherein dentists only saw patients a few times a year. "*We could patch them up or repair them, but we couldn't keep them healthy*". Gradually, dentists learned the regulatory issues, built more community partnerships, and promoted changes in the elder facilities to enable the creation of long-term on-site programs for daily dental care.

Community Collaborative Practice truly benefits from the teamwork model. This is particularly the case with on-site care delivery at elder care facilities where specialized training is required. Dentists are supported by team members at the community partner facilities, who provide invaluable assistance that would never be available to dentists in their private office. Receiving skilled help in managing senior patients with frailties, disabilities, or cognitive difficulties helps dental providers deliver a higher quality of care, more efficiently and cost-effectively.

Panel Discussion Highlights

In this second of two focus groups hosted by the Institute for Oral Health on their 2008 theme "Oral Health in Aging America", the panel of experts on geriatric dentistry addressed additional concerns in their open forum discussions, including the following issues…

Building incentive for geriatric dentistry

A major concern amongst the experts is in how to encourage more dentists to take on geriatric patients and all that that entails –getting specialized training, building community partnerships, upgrading their offices for accessibility, maybe even increasing staff. It's not a simple change.

Though there is potential to increase profitability through the added expensive procedures often required by seniors, serving older patients is significantly more time-consuming and may dominate a practitioner's schedule. With elderly patients, clinicians may need to spend a great deal of time examining a patient's medical and drug history, as well as coordinating with family and community care partners, all of which are critical to knowing which treatments are possible or best for that person. Dentists do not get paid for that, but it is an essential part of treating aging adults.

"Time is the thing with geriatric care – it takes time in nursing and in every health care realm, and dental clinicians don't get paid for their time, they get paid for procedures."

--Dr. Stephen Shuman

The panel discussed potential solutions, which included:

- Implement specialized billing codes for diagnostic procedures such as complex assessment and treatment planning that account for categories of special activities needed "to facilitate careful care" for special needs patients. Some clinics have a catch-all code for "behavior management" to cover extra time spent on these patients, but providers could really benefit from codes that specifically support and accurately address prerequisite exams. Additionally, insurance carriers could see a payback as providers may potentially reduce over-treatment through more detailed assessments.

- Develop a non-procedure-based compensation model for special needs dental practice. Rather than the current model of care delivery that's reimbursed based on the number and expense of procedures, a more time-oriented reimbursement model could provide incentive for improved health care and greater focus on patients.

  In special needs care, there's a catch-22. The provider's goal is to optimize patient health, and yet "good health" doesn't have any procedures or drugs associated with it, so from an economic standpoint, there is no money in it. Yet there is significant time involved in reaching positive outcomes and maintaining them as patients age. Thus, a reimbursement model based on invested time or desired outcomes would make more sense for special needs care delivery.

"For special needs care, we need a fundamentally different economic model that really focuses on the outcome that we want to produce, and rewards all the people, not just the dentists, but everybody in the team for doing the right things toward that end."

--Dr. Michael Helgeson

- Extend reimbursement models for risk assessment. Delta Dental in Washington has a plan that reimburses dentists for performing risk assessments, and they are now working to develop an economic model for dental offices that includes assessing outcomes, much like what is used for home health care facilities.

"Things need to change so that dentists are paid for their knowledge, understanding and management of disease."

--Dr. Ron Inge, IOH

Getting Dentistry to Embrace New Models for Access to Care

Dr. Jones introduced a number of innovative solutions that could help support uninsured and under-insured seniors, which raised the question: how do we get dentistry as a whole to embrace these plans? The group offered the following insights:

- Address it through the "pay or play" model – Even if providers are not able to or interested in actively participating in programs to improve access for needy populations, in some states practitioners contribute indirectly through paying a provider tax on their gross revenue. In this way, hundreds of millions of dollars are generated that can be translated into premium reductions and other access improvements for people in need.

  In fact, given the complexities and sensitivities required for treating special needs patients, the panel agreed that this tax is actually a better solution than getting every provider involved in care. As many aren't trained or interested enough to be able to provide high quality care, it's better to let those dentists focus on what they do best in their practice, but also have them contribute to a funding pool that can be tapped by special needs care providers.

"It takes a village... it will take all the different permutations working together to really get the job done."

--Dr. Judith Jones

- Offer incentives with targeted funding – The group acknowledged the need to get specialist partners involved, such as oral surgeons, whose expertise is critical in providing care to high-risk patients. Some state agencies help facilitate this through programs such as Minnesota's *Critical Access Program*, which supports providers helping needy populations by targeting resources in the places that are doing the most, and redistributing income to be used essentially as incentive bonuses to attract the participation of specialists.

"You have to clarify what is it you are purchasing, from whom, and how do you get the best value if it is public dollars."

--Dr. Michael Helgeson

Preparing for Diversity

In the coming years, dentists can expect to see more Hispanics, Asians and other ethnicities in their practice, where cultural and language barriers may make providing care more complicated. What should dental providers be doing to prepare for an increase of diverse populations in their practice?

- Promote diversity education – Dr. Shuman noted diversity programs now being implemented in some dental schools and clinics to educate providers on the various health expectations common to different cultural populations. These programs often include helpful videos on how to work with an interpreter. Some health plans cover professional interpreter services, and dental providers should encourage their patients with limited English to take advantage of that.

- Family members as interpreters – Providers should be aware of the pros and cons of having family members act as language interpreters. For example, while a family member may provide a comforting and helpful presence, they are rarely objective and may complicate decision making for the patient.

As time and productivity are an issue for all dental providers, interpreters may represent an interference. Yet their assistance and cultural insights might also smooth out and speed up the care process, so it's a worthwhile investment for practitioners to learn how to get the most out of working with a skilled interpreter.

Spending More Wisely on Dental Care

Another theme the group discussed was how insurance plans could spend in more effective ways. Pursuant to that, the panel agreed it is key for dentists to proactively track patients as they age in order to anticipate the type of care they will need in their elder years, including:

- What risk factors are they acquiring that will contribute to oral disease?

- What are their risks of chronic diseases and what disabilities are they likely to acquire?

- What's happening to their health as their medications steadily increase?

These factors will heavily influence how people will use a dental plan in their retirement, as well as the extent and complexity of their dental needs and accompanying medical complications. A common problem is that many people have insurance up until retirement, then they do not have coverage for a while –during which time their oral health deteriorates— then they end up on Medicaid. If they finally see a dentist again, it is at a time when their problems are more severe and costly, yet their coverage and income is more limited.

Dr. Helgeson noted a paper by Dr. Paul Glassman, DDS, which emphasized that, when considering a universal dollar amount for dental care across society as a whole (nearly $100 billion), that amount is still much less than the overall health care costs incurred as a consequence of people having chronic, untreated oral infections. In fact, a reduction of less than 1% in overall health care expenses would potentially pay for all this dental coverage. Additionally, an Aetna study showed that among healthy, working people who maintained regular dental care, there was an overall health care cost savings of 10%.

"We're wasting money in health care, and getting poorer health outcomes. We need to spend smarter by eliminating sources of infection --having untreated infections is a huge risk factor-- and that's essentially what we're talking about with neglected oral health."

--Dr. Michael Helgeson

The panel agreed it helps considerably if insurers work closely with the dental profession, and they noted a key benefit of the Institute for Oral Health is that it approaches solutions from a "plan perspective". As such, when IOH promotes advances and innovations for health plans, they may be more well received than when solutions come directly from providers.

Putting Solutions into Action

As Institute for Oral Health works to raise awareness and share education on critical oral health issues, it is also imperative to promote solutions that include practical recommendations that providers, insurers, and policymakers can put into action.

As many of the focus group participants are also featured speakers at the **2008 IOH National Conference** on **September 9 & 10, 2008**, they will include in their presentations action items or suggested opportunities to help others initiate and implement progressive solutions –for education and training, daily dental practice, and health care plan and policy development.

Additional Participants

Douglas Berkey, DMD, MPH, MS

Professor, University of Colorado Denver School of Dental Medicine; Dental Director, Total Longterm Care of Colorado; Past President of the Geriatric Oral Research Group of the International Association for Dental Research; Past Chair of the Gerontology and Geriatrics Education Section, American Dental Education Association

One of the leading geriatric dentists in the nation, Dr. Berkey is an internationally renowned dental academic and leader in teaching, research, and patient care related to geriatric and special care dentistry. Dr. Berkey participated in panel discussions for this Focus Group #2 in Denver. He was also a presenter at IOH Focus Group #1 held in February 2008 in San Diego, CA.

To learn more, please read the IOH Focus Group #1 whitepaper available on the IOH website at **www.iohwa.org**.

Dr. Berkey will also be a featured speaker at the **2008 IOH National Conference**.

To learn more about Institute for Oral Health, please visit the IOH website: www.iohwa.org.