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whitepaper

2010 conference

Oral Health in Healthcare Reform

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:: excerpt ::

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Introduction

> *"We can't continue to provide more expensive medical and dental care. We have to be able to provide less expensive and more effective dental care. Really that's about delivery system reform; it's not about payment or insurance reform."*
>
> –Dr. Michael Helgeson

This year's landmark healthcare reform signals positive change, but it also spotlights glaring weaknesses in our nation's healthcare system. Millions of Americans have no access to affordable quality dental care, and the dental profession lacks the workforce, training, and technology to effectively support the rapid growth in high-risk populations such as children, aging adults, and people with diabetes. So what happens next?

For the past four years, Institute for Oral Health (IOH) has focused on raising awareness about oral health concerns for these key populations, exploring progressive solutions to help advance dental care access, treatment, and delivery. In 2010, IOH addressed the theme of "**Oral Health in Healthcare Reform**," with an in-depth look at what's needed in healthcare reform and everyday dental practice to better support underserved populations. Additionally, we explored strategies for integration between dental and medical through collaborative practice models and information technology advancements that help drive evidence-based standards and treatment protocols to support more successful outcomes in both oral health and overall patient health.

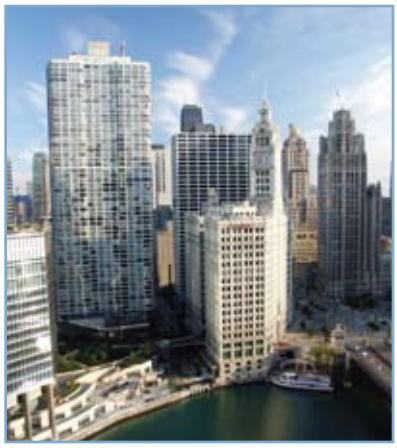
The October 2010 Institute for Oral Health Conference in Scottsdale, Arizona provided many valuable insights and promising solutions to advance oral health. With nationally recognized leaders in healthcare reform and top authorities in clinical practice, dental education, health benefits and health record technologies, this year's event highlighted a number of critical considerations, such as:

- Expanding the role of dentistry – From the economic challenges of supporting the expansion of Medicaid programs to provide care for 32 million more people, to the exciting new provisions that will promote prevention and early caries detection in millions of children, the Affordable Care Act provides many opportunities for dentistry to play a bigger role in the healthcare system.
- Addressing workforce challenges – As reform introduces new levels of need in the dental workforce, our system continues to battle with a lack of providers well trained to meet the unique needs of underserved populations such as aging adults and people with disabilities. In particular, with the wave of "boomers" reaching retirement age, our nation is facing an urgent need for more geriatric dentists. On a positive note, the reform bill includes provisions for numerous educational grants that could support better training for new and existing dental providers on special needs care.
- Increasing effectiveness with collaborative care models – The overwhelming consensus on healthcare reform is that both medical and dental will need to develop ways to deliver quality care at a lower cost. Several progressive delivery models were highlighted that focus on team-based care that brings together medical, dental and other caregivers with community partners to make access easier, reduce costs, increase efficiencies, and improve health outcomes for people who need care the most.
- Advancing quality using electronic health records – While electronic medical records have been in place for decades, emerging technology advancements are creating a place for dental to support

better integration with medicine. These tools provide opportunities for the critical data collection that drives quality measurements, performance analysis, and the development of evidence-based best practices.

- Improving health outcomes for diabetics – As increasing evidence supports the connection between periodontal disease and diabetes, dentists need to actively participate in helping diabetic patients control and manage both diseases. Calls to action include proactive risk assessments and dental provider education on diabetes, as well as close collaboration with physicians to partner on strategic treatment plans and early detection.

Looking Ahead to 2011



Oral Health and Prevention: Rebranding the Profession

October 27 & 28, 2011

Chicago, Illinois ~ Sofitel Hotel Water Tower

In 2011, the Institute for Oral Health will focus on prevention. We will collaborate with experts in focus groups and participate in national events to learn the latest in preventive strategies for improving health. 2011 will be an exciting year – stay tuned and please join us in Chicago!

About the 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.

Join the Conversation

IOH encourages everyone to get involved and share their insights and feedback about important oral health topics and healthcare reform:

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Michael Helgeson, DDS
Co-Founder and CEO of Apple Tree Dental

Oral Healthcare Reform: Older Adults and People with Special Needs

Providing oral health services to the rapidly growing population of older adults will require new systems of care delivery. A promising new model called "Community Collaborative Practice" extends the reach of dental practices and clinics by incorporating new dental team member roles and using new technologies to deliver dental care where older people and people with disabilities live, work, go to school or receive other health and social services. A leader in geriatric and special needs dentistry, Dr. Michael Helgeson shared how successful new models can be incorporated into state and federal health reform efforts.

As co-founder of Apple Tree Dental (now celebrating their 25th anniversary), Dr. Helgeson has helped develop and evolve the Community Collaborative Practice model to bring dental care to underserved populations at over 100 locations across the state of Minnesota. In his presentation, he also illustrated how their state-of-the-art mobile dental offices make it possible to deliver cost-effective, high quality care onsite at assisted living and nursing home facilities to improve oral health in vulnerable seniors.

The Impact of Medicaid Cuts on Oral Health

In today's healthcare system, aging adults and people with disabilities are poorly supported in terms of access and affordable coverage for oral health care --yet even basic oral hygiene maintenance can be a vital component in improving overall patient health and longevity. Much of the reform bill's oral health provisions focus on providing access to care for children, which is indeed valuable and needed. However, Dr. Helgeson noted that an "unintended side effect" of the reform transition has been substantial cuts in adult Medicaid coverage, which are severely impacting the disabled and those in long term care around the country.

> *"Deep cuts in Medicaid mean no coverage for people who are every bit as vulnerable and dependent as children. While reform is strengthening access for children, we've neglected that same kind of inspirational leadership to maintain coverage for our most vulnerable adults."*
>
> *– Dr. Michael Helgeson*

To illustrate his point, Dr. Helgeson showed a video developed by the Minnesota Dental Association, which was shared with legislators in early 2010 as a call to action to help many "safety net" dental clinics across the state whose patients rely on Medicaid to pay for services. The video highlights some of the severe challenges resulting from lack of access to dental care, from both the provider and patient perspectives. It is a powerful and poignant look at how profoundly oral health impacts lives. [You can view this video on the Institute for Oral Health website at IOHWA.ORG]

However, progress is being made. In May 2010, with support from the American Dental Association's National Elder Care Advisory Committee the Special Care Dentistry Act (HR5364) was introduced in the House of Representatives. This bill requires states to provide oral health services to people with disabilities and frail older adults under their Medicaid programs. Dr. Helgeson pointed out that it is a positive step forward towards ending "*discrimination against the disabled and the elderly in oral health care benefits. In medicine there's no parallel to abandoning people by age in terms of their right to have healthcare coverage, so this takes a step in that direction for oral health*."

As we look at the impact of healthcare reform on oral health and the dental profession, it is important to recognize that the Affordable Care Act (ACA) basically focuses on insurance reform. But we also need more cost-effective ways to provide care, which means delivery system reform. As such, Dr. Helgeson honed his discussion on ways to "*deliver dental care at a lower cost, and drive down wasteful healthcare spending by spending money on appropriate oral health care at the right time.*"

As further emphasis, he highlighted the fact that if we look at the severe health conditions related to uncontrolled, unmanaged infections in the mouth and the systemic complications they cause, the cost of providing comprehensive dental benefits for all the "aged, blind, and disabled" is ***less than one percent*** of what's being spent on the treatment of those conditions under Medicare and Medicaid. CConsider that any medical savings beyond that one percent actually drives down the runaway costs of healthcare.

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Another progressive development was the ADA-sponsored National Coalition Consensus Conference in November 2010 in Washington, D.C. The goal of the conference was "*to establish a broad and sustainable coalition of stakeholders who are committed to improving oral health in vulnerable older adults and persons with disabilities*." The coalition seeks to bring dentistry into collaboration with medicine, long term care, and patient advocacy groups to develop an effective, integrated coalition to improve dental care access, coverage, and delivery for special needs populations. This effort is building on the model of pediatric dentistry coalitions such as Dr. Joel Berg detailed at this conference, which have been highly successful in strengthening dental benefits and programs for children.

Improving policy in Minnesota

In Minnesota where Dr. Helgeson practices, a number of policy initiatives are underway to help special needs populations, defined as "the aged, blind and disabled," including:

- Limited Adult Benefits set to cover the most needed services that deliver the best outcomes, while reducing Medicaid spending.
- Alternative funding sources for dental services for patients in long-term care.
- Critical Access Dental Providers program to provide a "safety net" network of dental clinics in underserved areas to deliver care to special needs patients.
- Dental Services Advisory Council of clinical, educational, and administrative experts to advise Medicaid regarding the critical access dental provider program and on the effectiveness of dental services and best practices in care delivery.
- Dental Therapist and Advanced Dental Therapist programs to increase workforce capacity for special needs populations in underserved areas.

Achieving Progress with Team-Centered Care Delivery

With the goal of delivering care at a lower cost and with greater effectiveness, Dr. Helgeson highlighted the successful team-centered model used by the Mayo Clinic for over 100 years. Their strength and success lies, essentially, in their philosophy that "*the patient's interest is the only interest to be considered*." With their successes in mind, we need to look at policy goals for

healthcare and align our efforts to achieve the greatest good. This sentiment is echoed by the Institute of Medicine, which cited that, "*Access to care is the timely use of personal health services to achieve the best possible health outcomes*" —to which Dr. Helgeson added that, "*In dental care, that means not having dental problems or dental infections; it's not losing teeth; it's being able to maintain oral functions*."

As a strong believer in integrated, team-centered healthcare, Dr. Helgeson collaborated on Minnesota's Oral Healthcare Solutions Project some years ago to help develop new delivery system for oral healthcare. The initiative brought together a wide range of planning partners from professional dental organizations; special needs dentistry and safety net community clinics; dental education programs, Head Start and community action programs; health plans, public health and patient advocacy groups; state agencies and others. Together, this collaborative group worked to develop a new Oral Healthcare System featuring team-based Community Collaborative Practice. This new model extends the reach of traditional dental services beyond private practices and safety net clinics into the community where people "live, work, go to school, or receive other health and social services."

Community Collaborative Practice – How It Works

Community Collaborative Practice is a three-way collaboration between:

1. A dental practice (which may be a private office or safety net clinic)
2. A community partner such as a school, Head Start clinic, or nursing home, and an
3. Onsite oral health team, which works as a bridge for the other two partners

This model delivers interdisciplinary special care in collaboration with physicians, nurses, teachers, and social service providers in patient settings around the community –and does so by leveraging financial resources from the whole community.

Over 80 million Americans are considered "dentally underserved," people who cannot access dental care due to lack of affordable care, coverage, or available providers in their area. Furthermore, in special needs populations, patients often only think of going to the dentist when they have a problem, and they may have mobility or behavioral issues that make traveling to a dental office difficult or impossible. The goal of Community Collaborative Practice is to reach people while they are still healthy and keep them well with regular oral healthcare. He added that, ideally, the two-visits-per-year model should not really apply; we should provide tailored recall frequencies as needed to reach people before problems arise and keep them healthy, which in turn helps drive down costs when they do have problems.

As a model example of Community Collaborative Practice, Dr. Helgeson's own Apple Tree Dental in Minnesota has created a sustainable system for special needs adults and children. In 2009, they performed over 60,000 dental visits and screenings. 2010 marks their 25 year anniversary, and by the end of this year they will have delivered over 700,000 visits.

"Community Collaborative Practice is proactive delivery vs. passive access –delivering early education and prevention to high-risk populations before problems arise."

– Dr. Michael Helgeson

To deliver dental community-based care, Apple Tree contracts with each site using an "Oral Health Services Agreement" that clarifies needs and expectations, team roles, spaces used, records management, regulatory requirements, liability issues, and so on. A Dental Director leads the team and helps patients maintain relationships with their dentists and ensures there are oral health programs for all patients served by the community organization –children, adults, and elders. The team incorporates many new dental roles such as collaborative practice hygienists, dental therapists, and tele-dentists, who work together to increase the overall capacity to deliver dental care.

Community Collaborative Practice – Keys to Success

In reflecting on Apple Tree Dental's success, Dr. Helgeson noted, "*the value of dental care we provide has increased to about $12 million per year. As of 2010, the total value of dental care we've delivered will exceed $100 million. This was started by just four people who came together to create a group non-profit dental practice, inspired by the Mayo Clinic model.*"

He highlighted some key components that drive success in the Community Collaborative Practice model:

- Nonprofit organizational structure – As a non-profit, all the team members are aligned with and accountable to a common mission, which in Apple Tree's case is to "improve the oral health of people with special access needs who face barriers to care." This focus on mission helps alleviate much of the reactive, cost-centric thinking that sometimes occurs in traditional practices and promotes a more proactive, patient-centered perspective that ultimate helps support better healthcare delivery.
- Teams with essential areas of expertise – The team model goes beyond dental providers to build the infrastructure needed for community care delivery. Experts in geriatric, pediatric, and special care dentistry partner with experts in fundraising and nonprofit development, education, and public policy.
- Hub-and-spoke model – At the center of the new delivery system is the central clinic and operations center. From the center, year round services are delivered onsite at multiple community locations. This model optimizes the staffing and clinic resources needed to address complex patient needs.

"This model is an extension of the more old fashioned bricks and mortar dental home concept. It's more practical for patients who are highly mobile, and it's a way of maintaining ongoing quality of care."

– Dr. Michael Helgeson

- "Virtual dental home" – The Community Collaborative Practice model creates a central resource for oral health and provides "*a continuous source of dental services that provides care focused on patients and families, staffed by an interdisciplinary team linked together using tele-health technologies*."
- Advanced mobile dental offices – Apple Tree Dental is a "nationally recognized pioneer in mobile dentistry" and uses large trucks to transport compact, comprehensive mobile dental offices to more than 100 community locations across Minnesota. From nursing homes to Head Start centers to schools, this mobile delivery alternative costs only about one-third as much as medical transportation, staff time, and family time required to transport special needs patients to traditional dental offices.

- Proactive on-site care – A major cost-saving benefit of onsite care delivery at community locations is the ability to reach people where they live, work, and receive other services, and promote early education and prevention –before problems arise. Additionally, onsite care allows for collaboration between dental clinicians and other professionals at the site who are already well trained in working with people with special needs, such as nurses, social workers, and teachers. This teamwork provides a more comfortable experience for the patients and makes it quicker, easier, and more cost-effective for dental clinicians to deliver services.

Dr. Helgeson emphasized that when analyzing the economics of healthcare, Community Collaborative Practice offers a significantly more cost-effective way to deliver dental care. To provide equivalent services in a traditional dental model is not financially sustainable, but the non-profit model provides a total cost of care that is only about half the cost of traditional approaches. Additional cost benefits include:

- Proactive care delivery reduces overall dental costs as well as downstream medical costs treating systemic conditions like diabetes that are exacerbated by uncontrolled mouth infections.
- On-site care delivery costs only about one-third as much as the expense of medical transportation for special needs patients, additional staff time to accommodate mobility or behavioral issues, and family time away from work.

"The key is that we need more hands helping, we need more ways to deliver care, and we have to deliver care at a lower cost. It's really the only way out for our society."

– Dr. Michael Helgeson

- Collaboration with partners such as teachers and social workers at community sites helps patients become more receptive to oral health education and also creates positive peer pressures that trigger behavior changes that lead to better oral health and lower dental care costs.

Overall, the Community Collaborative Practice model makes it possible to achieve the mission of improving oral health –beyond simply providing dental care—for a large population in need, without discriminating based on age, health, or economic status. Along those lines, Dr. Helgeson highlighted how state reimbursement models need to be significantly revised to align with the best interests of patients:

> "*In our state's reimbursement model, dentists get paid twice as much to do a checkup for a child as they do for a medically complex adult --even though it may take as much time or more to simply read the chart of a medically complex patient as to perform two or three procedures on a child. The fee-for-service model is about as misaligned from patient-centered care as it can be. You need a nonprofit organization that can realign financial incentives to ensure that individual dentists and hygienists can do the right thing for each patient.*"

To learn more, please visit appletreedental.org