




  
 The 21st IAGG World Congress of Gerontology and Geriatrics
   
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**Global Aging and Health**
  
**Bridging Science, Policy, and Practice**

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**The Dental Gap: Mismatch between Policy and Oral Care Delivery Needs for Individuals in Long-term Care**

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# DISCLOSURE

I have no relevant commercial relationships to disclose.



## Background

Individuals living in LTC facilities or receiving in-home care (IHC) have poorer oral health status compared to individuals living independently.

Barriers to oral health care exist for the poor, elderly, and institutionalized population, including:

- Inadequate or non-existent dental insurance benefits for the elderly population;
- Limited geriatric training for dental providers; and
- Insufficient training and regulation around the provision of oral health care by providers in LTC settings

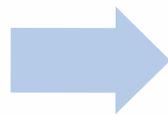


## Study Objectives & Methods

To advance understanding of current practice models utilized in providing dental services in long-term care facilities



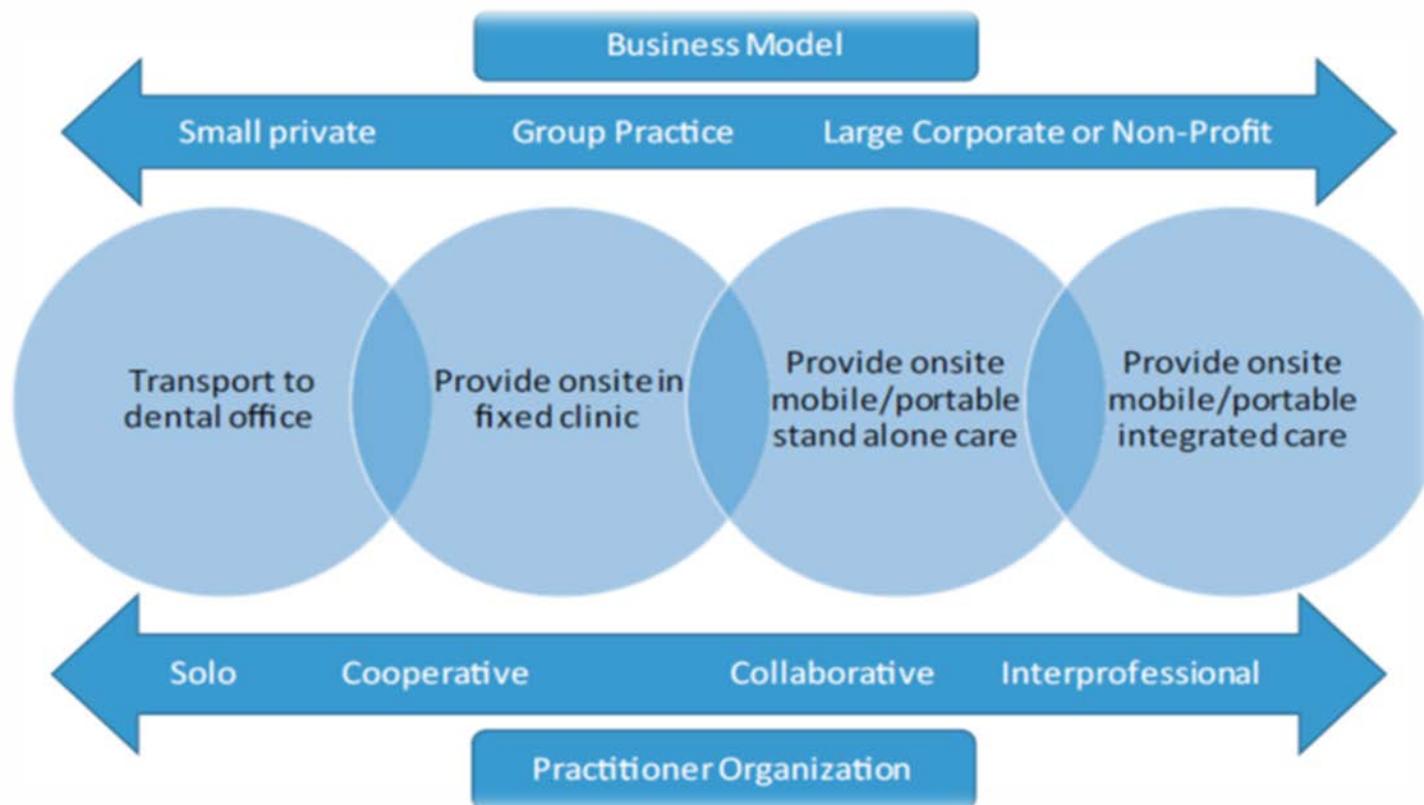
To identify the policy variables that impact the availability of oral health services in LTC settings and their range of variation in the U.S.



- A literature review;
- Interviews with state and national policy experts;
- Analysis of variation in Medicaid dental coverage and allied dental provider scope of practice laws by state; and
- Four state-based case studies were conducted in California, Florida, Minnesota, and North Carolina, including in-depth, qualitative interviews with dental & LTC providers.



# Continuum of LTC Dental Delivery Models





## Common Payment Sources

### Medicaid

- Adult coverage is optional

### Incurred Medical Expenses (IME)

- Highly idiosyncratic use

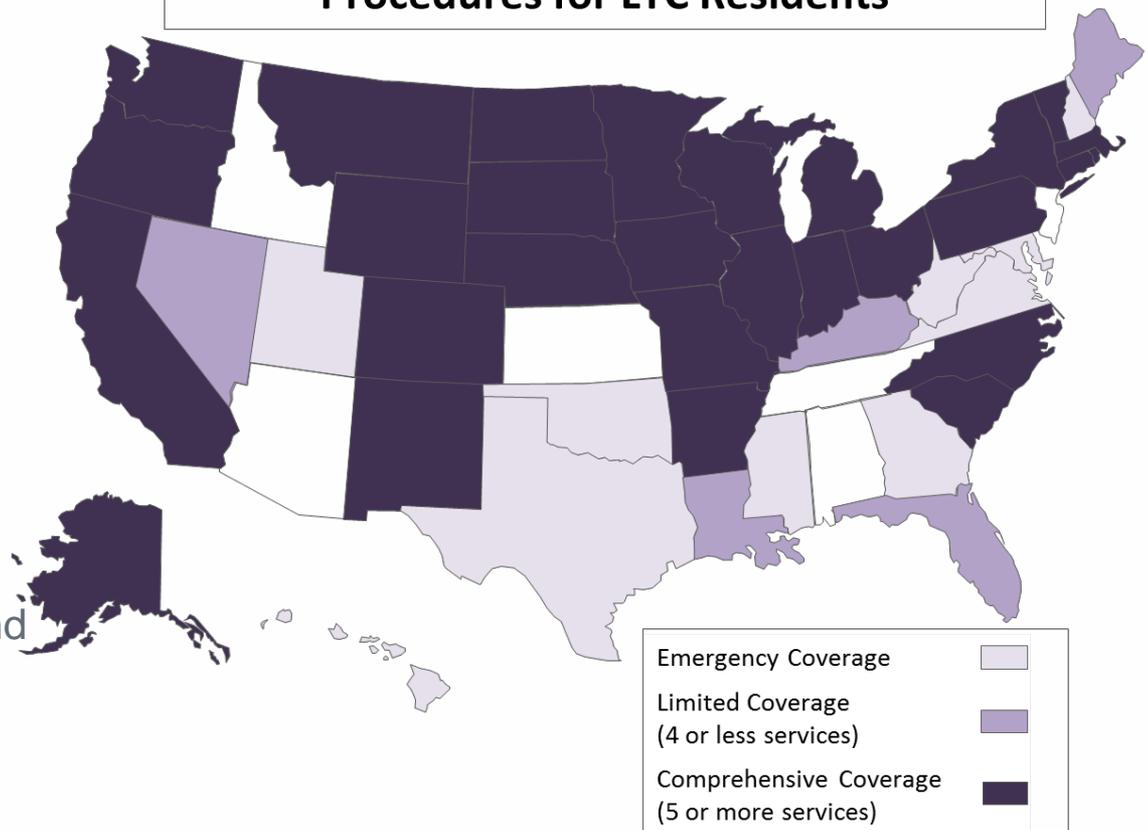
### Medicare Advantage

- Variable inclusion

### Self-Pay

- Almost no data on coverage and access for this population

## Medicaid Coverage of Common Dental Procedures for LTC Residents







# Medicaid adult dental benefits in study states

**California** – Comprehensive adult dental with copay of \$1/visit and pre-approval required for specified services including periodontal, crowns and root canals, pre-denture services, services for nursing facility residents

**Florida** – No coverage of adult dental under Medicaid except for services to alleviate pain or infection or preparatory or related to dentures with copay of 5% of payment/procedure. No pre-approval required for emergency services.

**Minnesota** - Non-pregnant adults limited to exam and cleaning 1/year, frequency of x-rays limited by type. Services require no copay and some specified services require pre-approval.

**North Carolina** - Exam and cleaning 2/year; frequency of x- rays limited by type; root canals limited to anterior teeth; orthodontia, pulp caps, inlays and crowns not covered. Copay of \$3 /episode of treatment. Pre-approval is required for Specified services including periodontal and orthodontic services and maxillofacial surgery.



## Expanded Allied Dental Workforce Policy

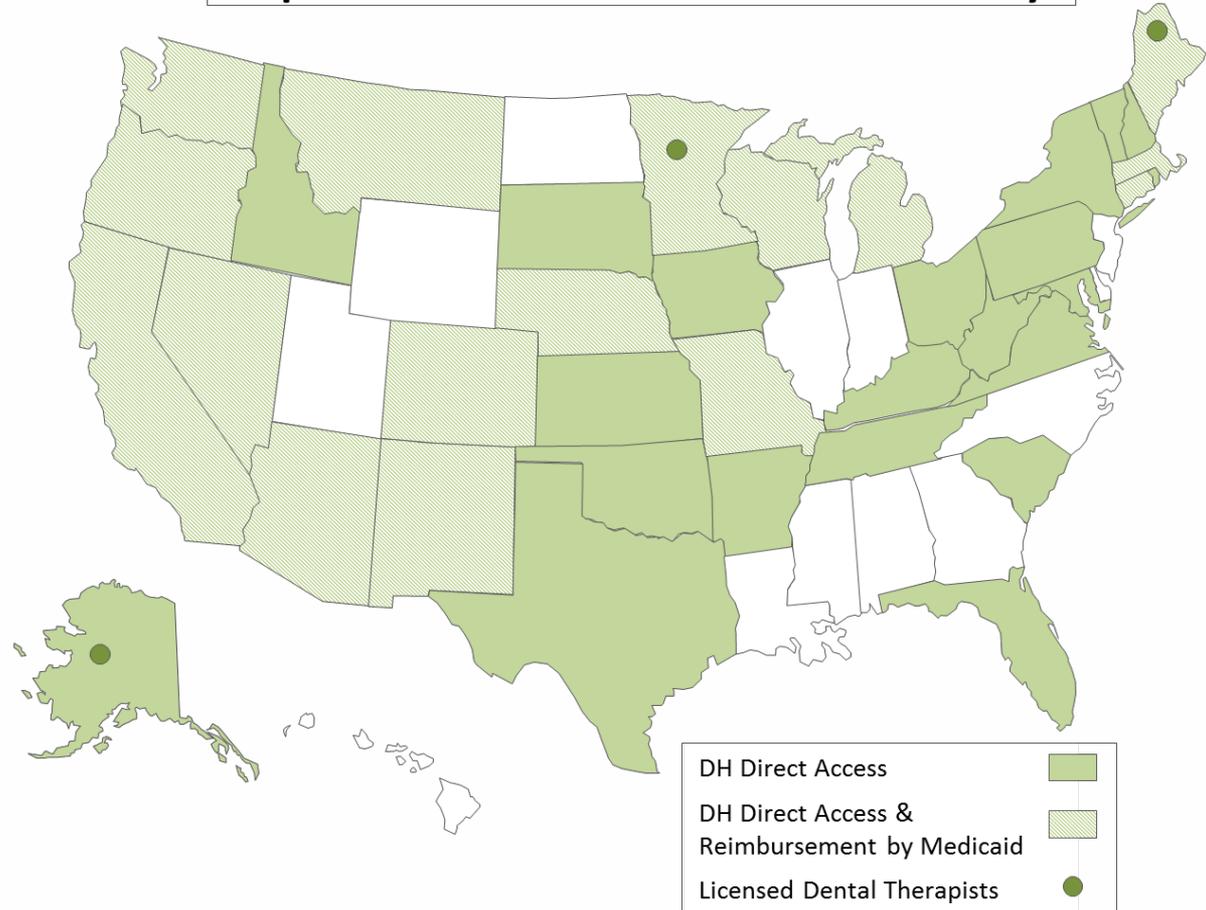
### Care is a Team Sport

#### LTC staff

- Nurses
- CNA
- Social Services
- Scheduler

#### Dental Team

- Dentist
- Hygienists
- Assistants
- Dental Therapists





## Workforce Supply

### **Formal training contributes less to current workforce capacity than personal motivation and desire to serve**

- Despite training models that have been shown to be effective (CA, NC) LTC staff are not often able to provide safe and effective daily mouth care for residents, even in states that require any training.
- Dental fellowships in geriatric dentistry have been de-funded although a handful of programs exist (for example at University of Minnesota)
- Providers report that internal motivation is the primary driver of practice choice, and that geriatric training is needed but probably won't change the overall supply of providers willing to serve this population under current policy conditions.



## State-by-state variability in approaches to care

**California - RDHAP & VDH** - Registered Dental Hygienists in Alternative Practice (RDHAP) use collaborative practices with dentists to expand access for LTC patients. The Virtual Dental Home (VDH) model uses tele-health technology. Denti-Cal supports adult care but has limitations that are challenging for providers.

**Florida - IME** - LTC dental care is facilitated by incurred medical expense (IME). Mobile dental providers use hygienists and dentists to provide prophylactic care at numerous LTCs in a given region. It is unclear how widespread this care model is, and treatment options are severely limited by the lack of Medicaid adult dental benefits in FL.

**Minnesota - DTs & payment policies** - Collaborative practice model between hygienists, dentists, and dental therapists (DTs), with comprehensive adult dental benefits and payment policies such as the “Critical Access Dental Provider Program” enables geriatric dental care.

**North Carolina - training program & mobile** - Scope of practice laws restrict use of hygienists for frequent preventive and comfort care. The Mouth Care Without a Battle© program trains LTCs seeking staff to improve daily oral care. A special care dentistry advisory group produced a strong set of recommendations, but these have not yet been implemented.



## Conclusions

**Workforce policies that enable serving LTC residents include expanded workforce training in geriatric dentistry as well as hygienist autonomy, billing abilities, and expanded practice.**

Mismatch: few geriatric training options and widespread state restrictions on scope of practice

**Care configurations that support LTC oral health include inter-professional practice, daily mouth care, mobile service delivery, and teledentistry.**

Mismatch: health professional education and payment systems do not support these configurations



## Conclusions

**LTC dental care requires a reimbursement structure that encourages safe, effective, and evidence-based dental care dental care**

Mismatch: no standard of care exists to drive policy, no Medicare dental benefit and Medicaid adult dental benefits are optional and insufficient

**Structural changes in policy at multiple levels is required if vulnerable and underserved patients are to get oral health services in these settings**

Mismatch: The will of policymakers and public payers is not mobilized around this issue



## Acknowledgements

<http://www.oralhealthworkforce.org>

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