



INSTITUTE FOR

Oral Health

IOHWA.ORG

whitepaper

2010 conference

Oral Health in Healthcare Reform

October 28 & 29, 2010

Scottsdale, Arizona



:: excerpt ::

Doug Berkey, DMD, MPH, MS

Writer | Designer: Gavin James
gjamesdesign.com

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:

IOH Web: IOHWA.ORG



Become a fan on Facebook



Follow us on Twitter (twitter.com/IOHWA)

Douglas Berkey, DDS, MPH, MS

Professor, University of Colorado School of Dental Medicine; Dental Director, Total Longterm Care of Colorado



Enhancing Oral Health for Vulnerable Elderly Through Innovative Models of Care

Oral health providers are facing an unprecedented challenge: increasing numbers of vulnerable older adults who have complex oral problems impacting their systemic health and quality of life. At the 2010 Institute for Oral Health Conference, Dr. Doug Berkey, a nationally recognized leader in geriatric dentistry, discussed medical and dental interrelationships that significantly affect the “at-risk” elderly and emphasized the need for collaboration between oral health, general health and social service professionals to facilitate better patient-centered care. He also identified several key policy factors that address this important challenge, and described PACE (Program of All-Inclusive Care for the Elderly), an innovative and comprehensive model of interdisciplinary healthcare delivery and payment endorsed by the Institute of Medicine.

Dr. Berkey began by highlighting what today’s dental practice is looking at in terms of the rising wave of “aging boomers.” Over the next 20 years, dentists can expect to see double the population of seniors in their practice, as well as a rapidly growing number of adults aged 85 and over as longevity rates increase and people are keeping their teeth longer.

In order to support this older population, Dr. Berkey stressed how we need to address key concerns such as the high impact of unmet oral health needs in the elderly, as well as workforce training challenges that influence care delivery. As a progressive solution, he detailed how the PACE program has successfully enabled integrated, patient-centered care along with innovative dental education.

“The fastest growing segment of our population is the oldest old (aged 85+). These are the people who present the greatest risks, the greatest challenges, and potentially the greatest rewards. We need to be thinking about how we can engage these individuals, take care of their needs, and promote the best health outcomes.”

– Dr. Doug Berkey

The Impact of Unmet Oral Health Needs in the Elderly

In aging populations, neglected oral health raises increasing challenges as it creates functional problems, mild to severe discomfort, and breeds infections that can worsen other systemic health conditions.

- **Poor functional status = malnutrition** – In the 1960’s, nearly 60% of adults over age 65 had dentures, compared with today, which has dropped to below 30 percent. “That’s good news and bad news”, said Dr. Berkey; it introduces a host of new concerns, such as determining a patient’s functional status and how it may be impacting their overall health. A current recognized benchmark in patients 65 years and older is that they need to retain at least 20 teeth in order to maintain sufficient chewing function for necessary nutritional intake (British National Diet and Nutrition Survey). Studies show that many older adults are prone to malnourishment, and poor dental function is a big contributor. 50% of older adults typically eat less than the recommended daily allowance for protein, and many are highly deficient in key vitamins and minerals. Furthermore, malnutrition often accounts for an increased risk of mortality, three times higher risk of infection, and significantly longer hospital stays.

■ **Untreated root caries, periodontal disease, and oral cancer** – Oral health problems are prevalent in many older adults. A national study showed that over 45% of men over 85 years had untreated coronal or root caries (NHANES III, 1988-94), and that nearly one quarter of 75 year olds and older may have moderate to severe periodontal disease (NHANES, 1999-2004). New data has recently emerged to suggest those numbers may have been underestimated by as much as 50%. Additionally, a new Massachusetts study conducted in 2010 cited that 60% of elders in nursing homes had untreated decay, with nearly 30% of them exhibiting major problems and up to 5% needing urgent care. Furthermore, oral cancer rates are rising, now considered as common as leukemia, killing one American every hour. Detected late, as it often is in older adults, the estimated survival rate is only 22%.

■ **Unreported oral health problems** – As adults age, they may be less able to feel the effects of caries or dental abscesses, so they may not complain about a problem until it grows very severe. Additionally, seniors often suffer from xerostomia (dry mouth) or burning mouth syndrome, caused by medications and other systemic health issues, which can impact oral health and general well-being.

.....
"In terms of prevention vs. costs, studies show that improved oral health saves greater than \$4 billion in treatment costs."

– Dr. Doug Berkey
.....

■ **Systemic health complications** – An increasing amount of data is surfacing linking inflammation as a key player in the oral-systemic connection. Oral infections are linked with numerous diseases such as diabetes, heart disease, pneumonia, and various cancers. Additionally, new studies identify how severe periodontal disease can reduce life expectancy and increase cognitive impairment in older adults. Conversely, an array of other domestic and international studies are showing that tooth retention is linked to increased longevity. For example, a Multicenter Scandinavian study cited that a higher number of teeth was a “significant predictor” of lower mortality rates in women. Furthermore, research is emerging to validate that “improved oral hygiene and frequent professional oral healthcare reduces the progression or occurrence of respiratory disease in high-risk elderly adults” (EBD 2007:8.4).

■ **Compromised quality of life** – An additional concern in neglected dental needs is the importance of oral health in terms of the social aspect, the aesthetics that affect one’s self esteem and comfort in relating to others. Dr. Berkey admits this notion is hard to quantify, yet it is integral to quality of life and thus, a key consideration for dental providers. While cosmetic dentistry has made a big business catering to younger populations, vulnerable older adults have the same fundamental need: to feel comfortable and confident in smiling and interacting with others as part of enjoying life.

Workforce Training Challenges in Geriatric Dentistry

As both an educator and clinician in geriatric dentistry, Dr. Berkey noted that future-of-dentistry reports (from the Institute of Medicine, ADA, Surgeon General, and so on) have confirmed that *“the dental workforce is not adequately prepared to meet the current and future health needs of older adults.”* The Institute of Medicine’s recommended strategy to build the necessary workforce includes three key action items:

1. **Enhance geriatric competence of the ENTIRE workforce** – Standardize pre- and postdoc curriculum with geriatric training and include clinical experiences and mentoring on caring for older adults beyond dentistry to include medical challenges, oral-systemic considerations, psychosocial concerns, and issues around access and affordability of care.

2. **Increase recruitment and retention of geriatric specialists** – Increase the number of postdoctoral geriatric training programs; include geriatrics as core curriculum for all general dentistry postdoctoral training programs; and provide integrated team training to promote collaboration with other elder care givers.
3. **Improve care delivery** – Develop innovative delivery models that address the unique needs of aging adults and expand the traditional scope of elder care, such as “coordinated, interdisciplinary team care to manage multiple medical, dental, and social needs.” Effective models include collaboration between all caregivers, preventive home visits, proactive rehabilitation, and caregiver education and support, and more (IOM, 2008).

PACE: A Viable Model for Care Delivery and Education

A hot theme in healthcare reform is one of Accountable Care Organizations (ACO’s), which under the ACA bill can contract with Medicare to provide care. ACO’s are promoted as “a mechanism to increase and sustain care quality, better manage chronic conditions, and control expenditures.” To achieve this lofty goal, a July 2010 Commonwealth Fund/Modern Healthcare Opinion Leaders Survey found that “integrated delivery systems” and ACO’s were believed to be the most highly effective at delivering on the reform promise. PACE, the Program of All-Inclusive Care for the Elderly, is one such model.

How PACE Compares with Current Long-Term Care

The PACE program is a national system of long-term care that provides community based managed care for the frail elderly. This model seeks to address some key problems with the current long-term care system, for example:

- **Centralized vs. fragmented resources** – Our current long-term system fragments resources across many providers and locations, making care more complex and costly, and less accessible for elders and their families. Communication is often poor between the various sites, which hinders the ability to support good patient health. With PACE, the integrated, community-based collaborative teams focus on providing a cohesive and comprehensive experience for seniors to access care and support for basic daily living.
- **Home care vs. institutions** – Long-term care typically does not support the common desire for aging adults to remain in the comfort of their own home and community. While PACE does offer nursing home and hospital care, the program focuses on providing outpatient care and home care to support seniors with healthcare needs while retaining their independence. In fact, despite a high level of care needs, over 90% of PACE participants are able to continue living in their community.
- **Proactive care vs. reaction to acute events** – Most often, acute events trigger access to long-term care, and as patients enter the system with severe needs requiring costly procedures, there exists no incentives for providers to control costs or utilization. PACE holds a proactive approach to promote early detection and prevention, along with basic home support services to enable older adults to stay in their home as long as possible. The model builds collaboration across numerous caregivers and social services to support more cost-effective, patient-centered care.

.....
“As we age, our goal is to age at home, and be able to access services so we can maintain our presence within the community. And yet most resources for long-term care are related to institutional care.”

– Dr. Doug Berkey

How PACE Makes a Difference

Designed to support the low-income, frail elderly and their families, the PACE model is “grounded in the belief that the community is the best setting to maintain the well-being of older adults with chronic care needs.” PACE organizes and delivers a range of services for acute and long-term integrated managed care in participant homes, community settings, and in/out patient facilities. The program supports everything from primary, specialty and home medical and dental care, to social services, transportation, meals and support resources.

As an example, “a PACE van might pick up an elder patient and take them to the PACE Day Center for breakfast, a clinic visit, a therapy session, or just for visiting with other participants. Or, PACE might schedule a Home Care visit to administer medications and make a home-cooked meal while they are there.” The program strives to offer any services and supplies necessary to help participants enjoy better health while remaining in their home.

The PACE model allows for more innovative care because it is not constrained by the fee-for-service payment model. Rather, services can be provided as they are needed, based on support from federal grants in connection with Medicare and Medicaid. In fact, some dental care and other services not covered by Medicare or Medicaid are built into the PACE model to help ensure better overall patient health, such as optometry, hearing aids, podiatry, prosthetics, and medical supplies. The system is capitated with a per-member, per-month payment structure and is designed to remove barriers to access by supporting patients with a lifetime enrollment that has no limits to the amount or duration of care, as well as no co-payments or deductibles.

At Denver, Colorado’s Total Longterm Care (TLC) facility where Dr. Berkey is Dental Director, they incorporate the PACE model to provide a “rich setting to teach, treat, and replicate” progressive, cost-effective services for seniors with challenging care needs. Total Longterm Care is now the largest PACE provider in the United States. Until 2008, there was only one facility in the greater Denver metro area; Total Longterm Care now operates five PACE centers in the region, and last year they provided 17,500 home care visits.

.....
“PACE studies cite “greater adult health care, fewer hospitalizations, fewer nursing home admissions, better functional status, better health, greater survival, greater satisfaction with overall care, and better quality of life.”
.....

– David C. Grabowski (2005)

How PACE Maps to Healthcare Reform Principles

The collaborative PACE model of care delivery is a positive step forward toward the promise of improving oral health and overall health –particularly for America’s underserved populations. Following are a few examples of how this type of integrated care delivery model maps to the ideals of healthcare reform as highlighted by the American Dental Education Association (ADEA) in 2008:

- **Increased availability of oral healthcare** – The ADEA acknowledged oral health as “a fundamental human need” integral to general health, and that successful reform must promote dental public health, prevention, and public advocacy through “new, integrated models of oral healthcare.”
- **Needs of vulnerable populations have top priority** – ADEA emphasized that our healthcare system needs to “improve access to care by reducing barriers experienced by low-income families, medically compromised individuals, and persons with special healthcare needs.” They called for “care model that expand roles for allied dental professionals and other health professionals to address the complex needs of some patients.”

- **Prevention as the foundation for good health** – ADEA promoted oral health prevention strategies to stem escalating costs and cited that *“most dental diseases are preventable, and early dental treatment is cost effective... preventive approaches have saved more than \$4 billion per year in treatment costs.”*
- **Focus on quality and not administration** – Another reform principle is to reduce the administrative burden of excessive costs that are unrelated to health outcomes and create new payment incentives for delivering quality care that improves overall health. Reducing overhead costs opens the door for *“reinvesting in the training of a 21st century healthcare workforce.”*

